

**IDENTIFYING BARRIERS TO TREATMENT
AMONG WOMEN GAMBLERS**

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Ninety female gamblers identified barriers to gambling treatment. These data suggest that the women in this study are a homogeneous group: middle aged ($M = 47$ years), Caucasian (86%), married or living with their partner (46%), had children (77%), completed a post secondary education (53%), employed full or part-time (67%), with personal incomes less than \$35,000 (61%), and household incomes between \$35,000 to \$79,999 (51%). Moreover, most were recruited by referral from the GA conferences or GA members (70%) and were living in Ontario, Canada (37%).

The Gamblers Anonymous 20 Questions and the South Oaks Gambling Screen were the two instruments used in this study to measure gambling severity. The average score on the GA20 was 17 and the SOGS was 13. Almost the entire sample (99% for the GA20 and 98% for the SOGS) can be considered to be compulsive or probable pathological gamblers.

The majority (81%) of women in this study received some type of formal help for their gambling problem. Forty-three percent received outpatient treatment, 41% received crisis help, and 27% received residential or in-patient treatment. All but one woman accessed informal help, including 91% who sought help from Gamblers Anonymous and 38% received help from the Internet support group CGHub. Eighty-four percent reported feeling seriously depressed; 74% related their depression to gambling. Thirty-three percent reported having attempted suicide; 57% related their suicide attempt to gambling. Almost half (47%) received treatment in

adulthood for a mental health or addictive disorder other than gambling, of which 60% were treated for depression.

Barriers to treatment were identified within 3 broad domains: individual, socio-environmental and programmatic issues. Correlations among the three barriers subscales were positive and statistically significant. Individual barrier items were identified most often and programmatic barriers were identified least often. The barrier item “gamble to deal with the stress of daily life” was most frequently endorsed. Respondents who received formal treatment reported statistically more barriers and had higher individual and socio-environmental barrier subscale scores than non-formal treatment seekers.

These findings suggest that women gamblers in this study have sought help from both formal and informal help systems. Key barriers to treatment are psychosocial issues. The women reported significant issues of comorbidity and concurrent life stressors, which may have important clinical implications providing appropriate and effective treatment to women addicted to gambling.

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1.0 INTRODUCTION

The problems among women associated with gambling are becoming more prevalent in our society. While gambling treatment programs exist, engaging individuals in treatment is very difficult (Centre for Addiction and Mental Health (CAMH), 2004; Potenza, Steinberg, McLaughlin, Wu, Rounsaville, & O'Malley, 2001). The National Council of Welfare (1996) estimated that between 2.7% and 5.4% of the population in eight out of ten provinces across Canada were problem or pathological gamblers. It is estimated that 3.4% of adults in Ontario, Canada, experience moderate (2.6%) to severe (0.8%) gambling problems (Wiebe, Mun, & Kauffman, 2005). Fewer women (3.1%) than men (4.5%) experience moderate to severe problems (Wiebe, Single, & Falkowski-Ham, 2001). In the United States, it was estimated that 1% to 4% of the general adult population were pathological or compulsive gamblers and women were thought to comprise approximately 30% (Shaffer, Hall & VanderBilt, 1999; Volberg, 1994; Volberg & Steadman, 1988, 1989). Between 1994 and 1998, a study conducted by the National Opinion Research Center (1999), reported that the percentage of women in the general population who ever gambled rose 20 percent, which was twice the percentage increase found for men.

Researchers concluded that only a small percentage of individuals experiencing gambling problems were seeking help from specialized treatment programs (Rush, Moxam, & Urbanoski, 2002; Toneatto, Boughton, & Borsoi, 2002; Volberg, 1994). From 1998 to 2002, approximately 1700 problem gamblers in Ontario, of which one-third were women, sought help from specialized treatment programs (Rush & Urbanoski, 2006). Of this total, one-third sought help

for problems relating to a family member or a significant other, widening the gender ratio of clients in treatment even more (Rush & Urbanoski, 2006). It is estimated that 1.4 to 2.2% of problem gamblers in Ontario will enter treatment in a specialized, government-funded program in a given year (Rush, Adlaf, Veldhuizen, Corea & Vincent, 2005). Volberg (1994) found treatment participation rates among problem gamblers to be close to zero.

Fewer women than men seeking treatment is especially problematic since women are reported to experience greater overall dysfunction as a result of gambling problems compared to men (Grant & Kim, 2002). Despite the psychological, emotional, social, and financial difficulties that are associated with a gambling problem, why do fewer women with a gambling problem seek help? And, how can social work play a role in eliminating barriers and improving access to treatment?

These questions underscore the need to conduct research on women who experience problems as a consequence of their gambling. Whether the reasons for not getting help originate from within the individual, from her social environment, or from the treatment system itself, they limit a woman's access to treatment. By identifying specific barriers to formal treatment, from the perspective of a sample of women gamblers, this study will increase awareness and address an issue that challenges social work and other allied health professions.

Pathological gambling (312.31) is classified by the DSM-IV-TR (2000) as an impulse control disorder that results in the preoccupation, tolerance, and loss of control of gambling behaviors. Prior to 1980, when gambling was first recognized as a pathological condition, the problems associated with this behaviour were regarded as an individual failing rather than a psychiatric or social problem (Lesieur & Blume, 1991).

Concerns about the low proportion of women gamblers in treatment programs began to emerge in the early 1990's. Female pathological gamblers were found to be less likely to enter treatment for a gambling problem and were thought to be 'under-represented' in treatment (Custer & Milt, 1985; Lesieur & Blume, 1991; Mark & Lesieur, 1992; Volberg, 1994). When prevalence rates for women who had developed problems as a result of their gambling behavior

were compared to rates of women in gambling treatment programs, researchers found that the percentage of women in treatment was not rising accordingly (Lesieur & Blume, 1991). Lesieur (1987), in his study of 50 female pathological gamblers in Gamblers Anonymous (GA), used the term ‘under-served’ to refer to the relative absence of women in treatment.

For women today “gambling is rapidly becoming a mainstream activity ... due to the recent legalization of new forms, changing social norms, more attractive prizes, and increasingly easy access to venues” (Boughton & Brewster, 2002, p. i). The ever-increasing availability and accessibility of gambling venues has resulted in the increased prevalence of problems related to gambling (Shaffer, Hall, & Vander Bilt, 1999). Gender differences in the resulting problems have begun to converge (Adlaf & Ialomiteanu, 2000; Shaffer, Hall, & VanderBilt, 1999).

Blackwell (2000) reported that “among young, female, ethnic and elderly gamblers ... treatment services touted by the Ontario government as an antidote to the province’s gambling boom are often of little help” (p. A10). The Canadian Institute of Health Research (2001) recognized the importance of improving access to health services for members of marginalized groups who have limited access to appropriate health services or feel constrained in accessing services even if the services are available.

Rush et al. (2005) assessed the geographic variation in the need for problem gambling treatment across Ontario, and the association with availability, accessibility and use of specialized problem gambling treatment programs. The study also looked at exposure to gambling venues and other demographic risk factors. The study found considerable regional variation in prevalence of problem gambling. The prevalence of problem gambling was associated with gender, age, employment status, education, mental health status, as well as co-occurring substance abuse problems and physical health status. Geographic access to treatment for problem gambling also varied across the province. A problem gambler living in close proximity to a gambling venue was more likely to be in treatment if the treatment program was also in close proximity. Rush et al. (2005) concluded “the treatment gap remains significant” (p. 32).

Research conducted outside Canada has shown a higher proportion of women in treatment than what has been reported in Ontario (Brown & Coventry, 1997; Crisp, Thomas, Jackson, Thomason, Smith, Borrell, et al., 2000; Grant & Kim, 2002; Moore as cited in National Research Council, 1999; Petry, 2003; Stinchfield & Winters, 1996; Tavares, Zilberman, Beites, & Gentil, 2001). For example, in Australia, Brown and Coventry (1997), and Crisp et al. (2000), attributed the influx of women into treatment to the use of non-residential supportive counseling and psychotherapeutic models by community-based treatment programs. Professional help-seeking estimates in Australia range from 7.3% to 10% (Productivity Commission Survey (1999), South Australia Department of Human Services Survey, 2001). In Brazil, Tavares et al. (2001) found a 1:1 ratio of men-to-women in an outpatient treatment program. In the United States, the National Impact Study Commission (1999) suggested that fewer than 10% of pathological gamblers ever receive professional treatment for their disorder. Stinchfield and Winters (1996) and Petry (2003) found that women comprised at least 40% of individuals entering professional treatment programs for gambling problems. Grant and Kim (2002) found that those entering treatment were mainly women (60%) who were more likely than men to seek pharmacological treatment for their gambling problem.

Women gamblers often experience personal and social consequences as a result of their gambling. Concurrent stressors, comorbid psychiatric problems, physical health problems, financial hardship, employment difficulties, legal issues, marital and family problems, and social isolation are among the problems reported by women gamblers (Boughton & Brewster, 2002; Lesieur & Blume, 1991; Petry & Armentano, 1999). These findings provide strong evidence of the importance of eliminating barriers to treatment so that women who need help for their gambling problem can receive it.

In the gambling literature, while several studies have addressed the issue of access to services, few studies have specifically investigated treatment barriers among women gamblers. Most studies conducted in recent years have included women gamblers, however, Brown and Coventry (1997) and Boughton and Brewster (2002) are the only exclusively female studies.

Brown and Coventry (1997) were the first to look at the issue of access to treatment services among female gamblers in Australia. Although the majority of women accessed support services, 31% reported that their experience with accessing assistance was negative, compared to the 28% who reported a positive experience with accessing services. The time delay in securing a counseling appointment, the limited availability of female counselors, the lack of transportation, and cultural and religious issues were among the barriers identified to obtaining treatment for problem gambling.

Marotta (1999) studied the recovery from gambling, with and without treatment, and identified factors hindering treatment seeking among 29 naturally resolved former gamblers (31% were female) and 29 treated former gamblers (45% were female). Marotta assessed the relevance of the nine potential reasons for not seeking treatment that were first identified by Sobell, Sobell, and Toneatto (1992). On a 5-point scale, ranging from 'had no influence' (0) to 'very much influenced' (4), participants were asked to rate how much each reason affected or influenced whether or not they sought help. The nine potential reasons included: treatment was not available locally; lack of information; embarrassment/anxiety; concerns about the stigma or label of problem gambler; negative attitudes toward gambling treatment programs; not wanting to share personal problems; cost; will-power/pride/own method; and denial or minimization of the problem. The most frequently endorsed reasons for not seeking formal treatment included the desire to resolve the problem on their own, denial and minimization of a gambling problem, and the embarrassment and anxiety associated with a gambling problem.

Hodgins and el-Guebaly (2000) theorized that many problem gamblers resolve their gambling problems on their own without treatment. To better understand the recovery process, 43 pathological gamblers who were abstinent (no longer gambling) were compared with 63 active pathological gamblers. Half of the sample was women. Participants rated on a 5-point scale the importance of eight potential reasons for not seeking treatment, paralleling Sobell, Sobell, and Toneatto's (1992) study for substance abusers. The potential reasons for not seeking treatment included embarrassment, no need for help, unable to share the problem, stigma,

wanting to handle the problem on one's own, cost, lack of availability of treatment, and other barriers. The majority of respondents reported never seeking treatment for their gambling problem (63% of the non-resolved and 53% of the resolved gamblers). The reason most commonly endorsed by subjects was a desire to handle the problem on their own (82%). Other factors that were moderately endorsed by respondents included: lack of awareness of availability of treatment programs (55%); the stigma associated with a gambling problem (53%); denial of a problem (50%), embarrassment and pride (50%); and, the difficulty in sharing problems (49%). Gender differences were not reported in this study.

Berry, Fraehlich and Toderian (2002) studied women's experiences with gambling, problem gambling, and help-seeking behaviour. This qualitative study used primary and secondary sources of data including information obtained from individuals who called in to a problem gambling telephone hotline, in-depth interviews, unobtrusive observations at two casinos, case files from bankruptcy trustees, and data from gambling addicted clients being seen at a specialized addiction service. Respondents identified the negative affects of gambling on their lives as financial concerns, relationship concerns, and emotional concerns. In terms of help-seeking behavior, this study asked respondents about their experience of 'talking to someone' about their gambling, and if their experience of taking to someone was helpful. They found few women actively sought help for their gambling problems.

Boughton and Brewster (2002) interviewed 365 women from across Ontario who were concerned about their gambling behavior but were not in treatment. The primary purpose of the study was to identify the barriers preventing women from accessing available services. The secondary goal of the study was to learn about the personal histories, gambling behaviors, and how female problem gamblers perceived a variety of issues. The study found that the majority (74%) were pathological gamblers and that 11% had sought gambling specific treatment and 9% had sought the help of GA, despite feeling a need to make changes. Treatment barriers were organized using two broad domains. The first domain, personal thoughts and feelings, included opinions about treatment services, concerns about comfort and safety in treatment, personal

feelings and thoughts (i.e., embarrassment, shame, fear), and irrational beliefs about being able to control their gambling. The second domain, practical barriers, included issues specific to external obstacles to accessing treatment such as time constraints due to work demands or responsibilities at home, finances or money issues, transportation costs, childcare expenses, and physical and mental health issues. Boughton and Brewster (2002) found that psychological and emotional issues were the key barriers to seeking treatment. The most reported barrier was the tendency to be self-reliant in managing change.

Rockloff and Schofield (2004) conducted a telephone survey of 1,203 individuals (49.7% women) in the general population. The study assessed the attitudes toward seeking treatment for a gambling problem. An abridged version of the SOGS was used to assess gambling severity. Survey items were taken from Sobell et al.'s (1991) and the Center on Alcoholism, Substance Abuse and Addiction's (1995) substance abuse questionnaires to assess barriers to treatment. The Barriers to Treatment for Problem Gambling Questionnaire consisted of 19 questions (responses ranged from 1 = strongly agree to 5 = strongly disagree), with five factors including: availability; stigma; cost; uncertainty; and avoidance. Only respondents scoring 'some gambling problem' (N=255) were correlated with factor scores. The gender ratio of the 255 participants used in this analysis was not given. Rockloff and Schofield (2004) found that individuals with higher SOGS scores were more likely to endorse the availability and cost associated with treatment as barriers; older respondents were more likely to endorse stigma as a barrier; and more highly educated respondents reported lower endorsement of all barriers. Gender differences showed that men were slightly more concerned with stigma and avoidance than women.

Evans and Delfabbro (2005) studied the primary motivators and barriers to help seeking in a sample of 77 (48 males and 29 females) gamblers; 16 (21%) used self-help methods only and 61 (79%) received professional help from a counselor, psychologist, or other paid or unpaid professional. All research participants had lifetime scores of 5 or more on the SOGS and had sought either formal or self-help methods to address their gambling problem. The study found

that the motivation to seek help from professionals was predominantly crisis-driven rather than being motivated by a gradual recognition of problematic behavior. The majority of gamblers sought help when they were facing a physical or psychological breakdown, and/or facing financial ruin. Severe depression and an inability to pay bills or to repay borrowed money were the principal sources of their problems. The primary barriers to help seeking were not a lack of knowledge or a dislike of treatment agencies, but rather, denial of a problem or embarrassment if friends or family found out, and a belief that they would eventually gain control on their own or would be able to gamble their way out of their difficulties. Overall, both groups (self-help and professional help seekers) identified psychological factors such as denial, embarrassment, and shame as the most significant barriers.

1.1 RESEARCH QUESTIONS

Using a framework that incorporated social work's ecological systems perspective as a way to understand treatment barriers, this study described the barriers to gambling treatment experienced by a sample of women gamblers. First, in terms of treatment barriers, this study addressed the following research questions about treatment barriers:

- a. What are the individual issues that create barriers to treatment for women who have a gambling problem?
- b. What are the socio-environmental factors that create barriers to treatment for women who have a gambling problem?
- c. What are the programmatic characteristics that create barriers to treatment for women who have a gambling problem?

Second, this study compared women actively involved in the gambling self-help group Gamblers Anonymous (GA) with those who were not actively involved in terms of the treatment

barriers identified. Third, this study compared the barriers to treatment identified by women who received formal help with the barriers reported by those who had not participated in formal treatment. Finally, this study compared the responses obtained from the two data collection methods used in this study – paper and pencil/administered versus email. Online research methods may be a useful and appropriate way of examining gambling, as it increasingly becomes a technologically driven pursuit (Wood & Griffiths, 2007).

To answer these questions, this study used a cross-sectional design. Respondents were recruited from GA and an Internet gambling self-help forum called CGHub. All respondents completed a self-administered questionnaire designed to obtain information regarding their gambling problem and specific barriers to treatment.

1.2 SIGNIFICANCE OF THE STUDY

Research is the primary vehicle for generating widespread consciousness of the extent and potential negative consequences of barriers to treatment for problem gamblers. The profession of social work is in a logical position to study the pernicious effects of this problem and the needs of this population. Whether barriers to treatment exist at the micro, organizational, or macro level, identifying the barriers to treatment among a sample of female gamblers who have experienced these problems can provide much needed information to treatment providers.

This study's findings will be useful to social work practice and in the development of programs for problem gamblers. The information obtained from this study can improve the fit between the person and environment, bridging the gap between women's help seeking and the gambling treatment programs and services that exist.

This study also raises interesting public policy issues. Across Ontario, specialized gambling treatment programs have expanded as a direct result of the proliferation of gambling

venues and the 1996 provincial policy to direct 2% of gross slot machine revenue to support problem gambling initiatives including treatment, community information services, prevention and research (Rush & Urbanoski, 2006). Statistics Canada reports, “gambling rates and the amount spent increases as household income rises, but families with the least money spend the biggest proportion of their income on gambling” (Proudfoot, 2007, p. A5). The Canadian Tax Foundation reported that “cash benefits of legalized gambling to society and to government outweigh the dollar costs, including those due to increased crime, health-care problems, job-related losses and family break-ups” (Beauchesne, 2000, p. A10). Yet, government has a social responsibility to minimize the risks and adverse consequences associated with gambling. One way to do this is by eliminating barriers and providing treatment that is responsive to the unique needs of women gamblers and their families. The potential link between the need for treatment and access to treatment is a key public policy issue that the social work profession can attempt to influence.

This study is both germane and timely for the profession of social work. The process of identifying treatment barriers and understanding the extent to which they exist for women gamblers has been hindered by a paucity of research. “Research now faces the challenge of explaining why some people accept these treatments and some do not even try, why some engage with mental health services and some drop out, and how professional and service delivery systems influence adherence” (Korr, 1998, p. 98). Women gamblers accessing informal types of treatment are in a unique position to identify real or perceived barriers to formal treatment.

Several factors make this study unique. First, the theoretical framework that informed this study is social work’s ecological systems perspective. This ‘person-in-environment’ framework focuses on complex interactions among social systems with the goal of creating a ‘better fit’ between the person and her environment. The person plays a dynamic role - shaping and being shaped by the situation she is in (van Wormer, 1995). From this perspective, individual, socio-environmental, and programmatic barriers that affect the relationship between the individual gambler and gambling treatment can be examined.

Second, the study locale is unique in its bi-national character. Windsor, Canada, borders Detroit, USA, and is home to four large casinos. Women gamblers were recruited from across southwestern Ontario and Michigan.

Finally, this study derived its sample from a population of women from GA and from an online gambling self-help group called Compulsive Gambling Hub (CGHub). As well, self-help groups play an important role in providing support (Wituk, Shepherd, Slavich, Warren, & Meissen, 2000). GA, as an alternative (and often adjunct) to more formal treatment methods, has been virtually unexplored in terms of its effectiveness in helping pathological gamblers (Ferentzy & Skinner, 2003; Petry, 2005). Even more elusive is knowledge about the outcomes of online help for problem gamblers (Cooper & Doucet, 2002). Electronic support groups can augment standard interventions and may reach individuals who are reluctant or unable to use existing “in-person” or “real-time” services (Galanter & Brook, 2001). This study also provides information about these fellowships in their role as mutual aid support for women gamblers.

2.0 LITERATURE REVIEW

For a growing number of women, the problems associated with their gambling addiction cause economic, social, physical, emotional, and spiritual hardship, and create devastating consequences for themselves, their family, and their community. While treatment programs exist to address the problems associated with gambling, women appear to be less likely than men to use these services (Berry, Freahlich, & Toderian, 2002; Lesieur & Blume, 1991; Mark & Lesieur, 1992; Rush, Moxam, & Urbanoski, 2002; Weisner & Schmidt, 1992). Unique barriers impact women's help seeking (Boughton & Brewster, 2002). Barriers include denial, stigma, limited resources, the lack of support from family and friends, and the lack of specialized training by professionals. The gap between the reported need for gambling treatment and the number of women accessing services has resulted in a unique social problem that is the focus of this research.

This chapter reviews the literature on barriers to treatment. It provides a brief discussion of gambling pathology, current treatment models, and the ecological systems perspective, which was used as a framework to better understand the multi-faceted context of this problem.

2.1 CONTEXTUAL BACKGROUND

The following information regarding gambling as a pathological condition, the treatment that is currently available, and the risk factors associated with woman gamblers provides a contextual background for the subsequent discussion of barriers to treatment.

2.1.1 Diagnostic Criteria

In 1980, the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-III) included pathological gambling as a diagnosable mental disorder that required treatment. The diagnostic criteria were perceived as providing a conceptual basis for health care providers to treat gambling-addicted individuals (Blume, 1987). Prior to that time, problems associated with gambling were regarded as an individual weakness or failure (Lesieur & Blume, 1992). The diagnostic criteria for pathological gambling changed in 1987 in the DSM-III-R to include the physiological symptoms of tolerance and withdrawal, and then revised once again in 1994 with the DSM-IV (Blume, 1987; Lesieur & Rosenthal, 1991, Stinchfield, 2002). Categorized as a Disorder of Impulse Control Not Otherwise Classified, the classificatory emphasis is on the disruption to the individual's family. Personal, or vocational pursuits, where the individual repeatedly fails to resist the impulse to gamble despite negative consequences and the disruption of life (DSM IV-TR, 2000). The ten diagnostic criteria for pathological gambling are presented in Table 1.

Table 1. DSM-IV-TR Diagnostic Criteria for Pathological Gambling (312.31)

<p>A. Persistent and recurrent maladaptive gambling behavior as indicated by <u>five</u> (or more) of the following:</p> <ol style="list-style-type: none"> 1) is <u>preoccupied</u> with gambling (e.g. preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble); 2) needs to gamble with <u>increasing amounts of money</u> in order to achieve the desired excitement; 3) has <u>repeated unsuccessful efforts to control</u>, cut back, or stop gambling; 4) is <u>restless or irritable</u> when attempting to control, cut back, or stop gambling; 5) gambles as a way of <u>escaping</u> from problems or relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, depression) 6) after losing money gambling, often <u>returns another day</u> to get even ('chasing' one's losses); 7) <u>lies</u> to family members, therapist or others to conceal the extent of involvement with gambling; 8) has committed <u>illegal acts</u> such as forgery, fraud, theft, or embezzlement to finance gambling; 9) has <u>jeopardized or lost a significant relationship</u>, job, or educational or career opportunity because of gambling; 10) relies on others to provide money to <u>relieve a desperate financial situation</u> caused by gambling
<p>B. The gambling behavior is not better accounted for by a Manic Episode</p>

2.1.2 Treatment

Gambling treatment is intended to help minimize harm to self and others, avoid risky situations, cope with negative mental states, and improve the quality of life (Korn, 2002). Twenty years ago, Lesieur and Custer (1984) identified professional counseling and Gamblers Anonymous as the only options available for treating problem gamblers. Today, in Canada and the United States, various interventions exist, are available in both formal and informal settings, are often combined offering a multi-modal approach, and may or may not include medication (National Research Council, 1999; Toneatto & Ladouceur, 2003). Table 2 presents these treatment options. Non-residential interventions appear to be the most popular, with Gamblers

Anonymous being the most widely used intervention (Boughton & Brewster, 2002; National Research Council, 1999; Petry, 2003; 2005).

Several caveats must be acknowledged when assessing gambling treatment effectiveness. First, gambling treatment research has been characterized by multiple methodological flaws (small samples, uncontrolled interventions, case studies) and second, treatment attrition (Toneatto & Ladouceur, 2003; Westphal, 2007). Westphal (2007), suspects that gambling treatment effects are overestimated.

The estimates of attrition in different types of gambling treatment: short term pharmacological treatment (23.5%), psychosocial (42%), long term pharmacological treatment (50.4%), GA (67.5%) and community multi-modal (75%) are substantial. Its estimation of

Table 2. Gambling Treatment Options

<u>Treatment Option</u>	<u>Treatment Provider</u>	<u>Treatment Setting</u>	<u>Treatment Type</u>
Formal (Direct)	Professional	Residential (In-patient)	Individual Group (may include couple and/or family counseling)
		Non-residential (Out-Patient)	Individual Group Couple/ Family Crisis hot-line
		Private Counselor or Therapist	Individual Couple Family
Informal (Direct)	Non-Professional	Self-help	Gamblers Anonymous Internet Chat Room or Group
Informal (Indirect)	Non-Professional	Self-help	Manuals/Workbooks

treatment effects have been based on patients who complete treatment, gambling treatment effects are likely overestimated. Attrition among gambling treatment participants is a robust and substantial phenomena, occurring in diverse sites and diverse treatment modalities over more than two decades of investigation. (p73)

2.1.3 Formal Interventions

Residential or inpatient treatment is the most intensive form of treatment for pathological gamblers. Rosenthal (1992) identified several reasons for admission to residential/inpatient treatment programs. He wrote, “inpatient treatment should be considered when the gambler is unable to stop gambling, is multiply addicted, or has significant comorbid pathology, lacks sufficient support from family or others, is physically or emotionally exhausted, severely depressed, suicidal, or contemplating some dangerous activity” (p.77). Residential treatment programs use multidisciplinary teams to provide treatment, and may include gambling counselors, social workers, psychologists or psychiatrists. Typically, treatment involves three stages: acute intervention, rehabilitation, and maintenance. These three stages vary according to the philosophy of the provider, the settings in which the treatment takes place, and the specific approaches employed (National Research Council, 1999).

Non-residential or outpatient treatment programs include walk-in and crisis services, and usually provide individual, group and/or family counseling, and telephone counseling. Certified gambling counselors, addiction specialists, or therapists provide case management in addition to referrals to other services such as mental health treatment, credit counseling, legal services and other programs, including Gamblers Anonymous. Ontario’s comprehensive problem gambling strategy has expanded to a TeleCounseling service, delivering confidential telephone counseling that includes six 45-minute treatment sessions over an 8 or 10-week period (Toneatto, 2004)

Private therapy and counseling services are provided by licensed professionals including social workers, psychologists, psychotherapists, and certified addiction counselors. These professionals can deal with all aspects of the addiction. According to Rosenthal (1992), “in the hands of an experienced therapist, pathological gambling is an extremely treatable disorder” (p. 76). Based on the individual’s needs, the therapist can provide couple, family, and/or group counseling in addition to individual counseling.

Psychoanalytic, psychodynamic, behavioral, cognitive, and pharmacological treatment approaches are among those used in formal treatment programs. Often, treatment programs and professionals combine approaches or elements from these approaches in treating clients. The psychoanalytic and psychodynamic models view pathological gambling as a symptom or expression of an underlying psychological condition. Treatment is focused on helping the individual gambler understand the underlying source of distress so that he/she can confront it (National Research Council, 1999). Behavioral models are based on the principle of classical conditioning and operant theory. Gambling is regarded as a learned behavior that is initiated and maintained by positive and negative reinforcement (Anderson & Brown, 1984). Behavioral counseling is used both in individual and group treatment settings and clients receive reinforcement for desired gambling behaviors such as gambling at reduced levels or complete cessation from gambling. Cognitive models are based on the belief that gamblers possess irrational core beliefs about gambling despite serious losses (Walker, 1992). These beliefs are referred to as ‘irrational thinking.’ The gambler is said to ‘chase the loss’ and perceives a loss as ‘due to chance’ and a win as ‘due to skill.’ Treatment seeks to change irrational beliefs and attitudes about gambling and involves teaching ways to correct thinking and change behavior.

The belief that an addictive behavior is a medical condition is the basis for pharmacological models that use medication to curb the urge to gamble. In clinical trials, the drugs clomipramine and fluvoxamine have shown positive results in decreasing cravings and achieving abstinence (Hollander, Begaz & DeCaria, 1998; Hollander, Frenkel, Decaria, Trungold & Stein, 1992). Also, the drug nalmefene, an opiate antagonist has been posited as a potential

pharmacotherapy for pathological gambling (Grant, Potenza, Hollander, Cunningham-Williams, Nurminen, Smits & Kallio, 2006; Kim, Grant, Adson & Shin, 2001). Naltrexone effects dopamine function, targeting the brain's system for processing pleasure and receiving rewards. Opioid antagonists have been effective in treating other substances such as alcohol, heroin and cocaine abuse. Grant et al. (2006) studied 207 people (43.5% were women) diagnosed with pathological gambling and randomly assigned them to receive nalmefene (25mg/day, 50mg/day, or 100mg/day) or placebo. Fifty-nine percent of those receiving 25mg/day were rated as "much improved" or "very much improved," demonstrating efficacy superior to placebo (34%) in terms of the overall response to treatment, as measured by the CGI (a reliable and valid 7-item scale used to evaluate change in pathological gambling symptoms).

2.1.4 Informal Direct Help

Self-help is the most common and the most widely used form of assistance for pathological gamblers. In recent years self-help approaches have expanded to the Internet. The most notable and accessible form of self-help for gamblers is Gamblers Anonymous (GA) (Lopez Viets, & Miller, 1997). Modeled after Alcoholics Anonymous (AA), "one notable feature of GA is its emphasis on patience in the recovery process, reflected even in its approach to the 12 Steps, which are "worked" at a slow pace..." (Ferentzy & Skinner, 2006, p. 1). Membership includes both women and men and is exclusive to those who believe they have a gambling problem. Members are counseled on the financial and legal challenges associated with this addiction (Ferentzy & Skinner, 2003). For many, GA becomes "not just a treatment but a whole new way of life, both spiritually and socially" (Stewart & Brown, 1988, p. 284). Using group therapy techniques, GA meetings are facilitated by lay people who are abstinent (Lester, 1980). Meetings occur several times a week; in some cities meetings take place daily and in several

locations throughout the city. Compulsive gambling is understood as an emotional illness and GA promotes life-long abstinence and membership (Haswell, 1999). Female membership has grown in the last 20 years from 4% to 20% in some areas (Custer, 1982; Ferentzy, Skinner, & Antze, 2003). “Members provide emotional support to one-another, learn ways to cope, discover strategies for improving their condition, and help others with helping themselves” (Wituk, Shepherd, Slavich, Warren, & Meissen, 2000, p. 157). Membership means adopting the 12 principles for recovery, or the 12 Steps. Powell (1997) compared ‘self-help’ to churches where members are supported when “doctrine (ideology) and ritual (procedures)... ameliorate distress and give meaning to life” (p. 57). Petry’s (2003) study evaluating prior GA participation rates among 342 consecutive admissions to professional gambling treatment programs found that gamblers who chose to attend GA and professional treatment did better (in terms of gambling abstinence or reducing their gambling behavior) than those who presented for professional treatment but did not become actively engaged in either GA or professional treatment.

Computer-based self-help groups are a recent development (Finn, 1995). Through this medium, with its 24-hour accessibility and anonymity, participants acknowledge a common experience and receive support that is intended to diminish unresolved feelings of shame and guilt. Available to those with Internet access, privacy, convenience, safety, and portability are among the inherent advantages of using the Internet as a self-help medium (Cooper & Doucet, 2001). “Computer-mediated communication, echoing other quantum leaps in technology, is transforming social lives on a global scale as networks formed in cyberspace reach across group boundaries, space, and time itself.” (McGowan, 2003, p. 1)

2.1.5 Informal Indirect Help

Educational materials, self-help workbooks, and tapes or videos provide an alternative and an additional support in treating gambling problems. Hodgins, Currie, and el-Guebaly (2001) suggested, “Self-help work-books may be an attractive, accessible, and cost-effective alternative to attending treatment programs or self-help groups” (p. 50). Hodgins and el-Guebaly (2000) compared resolved and active gamblers and found self-help workbooks to be effective among the individuals in their study with less severe gambling problems who were concerned with privacy and convenience and who wanted to handle their gambling problem on their own. Hodgins, Currie, and el-Guebaly’s (2001) study of 102 participants (52% female) compared two self-help protocols with a waiting-list control group and followed-up at 3, 6, and 12 months. The first self-help protocol included providing a self-help workbook via email. The second protocol included a motivational telephone interview prior to receipt of a self-help workbook. Hodgins et al. (2001) found that the combined workbook and motivational enhancement were effective in reducing gambling behavior over a short to medium period of time, though, no significant group differences were found at the 12-month follow-up.

2.1.6 Risk Factors Associated with Women Gamblers

Increasingly, risk factors such as comorbid substance abuse, mental illness, and victimization are being identified in studies involving gambling addicted women, in and out of treatment (Brown & Coventry, 1997; Collins, Skinner, and Toneatto, 2003; Crisp et al., 2000; Crockford and el-Guebaly, 1998; Getty, Watson, & Frisch, 2000; Grant & Kim, 2002; Langenbucher, Bayly, Labouie, Sanjuan, & Martin, 2001; Lesieur, 1987; Petry, 2003; Petry, Stinson, & Grant, 2005; Potenza et al., 2001; Rupeich, Frisch, & Govoni, 1997; Rush et al., 2005; Shaffer, Hall, & Vander Bilt, 1999; Toneatto & Brennan, 2002; Urbanoski & Rush, 2006). Women are

confronted with different risks due to factors tied to their biological and social characteristics (Health Canada, 1999). Shaffer et al.'s (1999) meta-analysis of the prevalence of gambling problems in the United States and Canada identified psychiatric comorbidity as a risk factor for gambling disorders. While the prevalence of pathological and problem gambling observed in mental health settings is four to six times the rate found in general population studies, problem gambling is often not detected or not dealt with in general treatment settings (Collins, Skinner & Toneatto, 2003; Langenbucher et al., 2001; Rupcich, Frisch & Govoni, 1997). Grant and Kim (2002) stated that "few patients with PGD actually present for treatment for pathological gambling: more enter treatment due to suicide attempts and substance use disorders" (p. 56).

Referring to the feelings of guilt, inadequacy and low self-esteem that are often associated with problem gambling, Volberg (1997) stated that "the addictive behaviour temporarily diminishes these negative feelings and allows the addicted person to engage in pleasurable fantasies" (p. 325). Some women gamble to escape unpleasant situations in their lives. For others, gambling offers a solution to some of life's problems (Crisp, Thomas, Jackson, Thomason, Smith, Borrell, Ho, & Holt, 2000; Lesieur & Blume, 1991). According to Boughton and Brewster (2002):

Just as many women who seek treatment for chemical dependence are addicted to tranquilizers; many female gamblers are seeking a way to numb emotions, shut out the world and orchestrate a time out. Gambling for the escape gamblers is a 'psychic anesthetizer' with tension relieving and anti-depressant (analgesic) effects. It provides relief from the psychic distress, including anxiety, depression, anger, loneliness, emptiness, boredom, worry, and hopelessness. (Sec. I.1.3)

Lesieur recognized the increased risks associated with pathological gambling in his study of 50 women gamblers where 13 women (26%) suffered serious depression made worse by their gambling related problems (Lesieur & Blume, 1991). In Brown and Coventry's (1997) research, 57 women (56% of the sample) identified gambling problems as having affected their health. Although depression was present in 30% of this sample, women also reported suffering from stress, anxiety, lethargy, insomnia, suicidal thoughts, increased caffeine and nicotine

consumption, confusion, panic attacks, and ulcers. Rupcich, Frisch, and Govoni (1997) found that among 108 women in treatment for substance-use disorders, 17% were probable pathological gamblers.

Crisp et al. (2000) found that among the 583 female and 696 male clients of the Australian problem gambling service, *Break Even*, women were 1.9 times more likely than men to report problems related to mood and anxiety. Getty, Watson, and Frisch (2000) found higher rates of depression and reactive coping among a sample of ten female pathological gamblers in Gamblers Anonymous, in comparison to 20 male pathological gamblers in GA and 30 non-pathological gamblers (20 male and 10 female).

Among a sample of 200 gambling treatment seekers (25% of whom were women), Toneatto and Skinner (2000) found that when compared to men, female pathological gamblers reported higher rates of lifetime psychotropic drug use, abuse of medication, treatment for abuse of medications, medication use at the time of seeking treatment for gambling, and medication use during the twelve month follow-up period post-treatment.

Potenza et al. (2001) found significant gender differences in the psychiatric symptoms attributed to gambling. In their sample of 562 callers to a gambling help-line service in Connecticut, high rates of depression and anxiety were reported by both men (78%) and women (84%); however, female gamblers were significantly more likely than male gamblers to report anxiety and suicide attempts as a result of their gambling. Potenza et al. (2001) suggested that the co-occurrence of mental health problems or substance abuse with pathological gambling compels gamblers to avoid seeking help or to address problems other than gambling addiction problems in non-specialized treatment settings.

Langenbucher, Bayly, Labouvie, Sanjuan and Martin (2001) concluded that gambling was an important comorbid condition to substance abuse. Of the 372 substance abusers in treatment who were enrolled in their study, 49 (13%) were identified with pathological gambling disorder, and six (10% of the female sample) were women.

Toneatto and Brennan (2002) found evidence of the comorbidity of substance abuse and pathological gambling disorder. In their sample of 580 people seeking residential addiction treatment, 7.5% of women were considered to have pathological gambling problems; however none were seeking treatment for gambling problems.

Boughton and Brewster (2002) found high rates of addiction and psychiatric comorbidity among their sample of 365 women gamblers. The women reported histories of emotional, physical, and/or sexual abuse in childhood and adulthood. Depression was most often reported (63%), followed by anxiety (53%), and panic disorder (28%). Almost half (45%) reported suicidal ideation and 29% reported attempting suicide. Overall, 18% of respondents reported that depression and 16% identified anxiety as preventing them from getting help for their gambling problem. Experiencing emotional abuse as a child was reported by 63% and 69% reported experiencing emotional abuse as an adult. Physical abuse experienced in childhood and adulthood was reported by 41% and 46% respectively. Sexual abuse in childhood was reported by 38%, and 28% said they had experienced such abuse as adults. The incidence of abuse in childhood was higher in this sample than in the general population. Approximately one-third of the sample reported spousal problems including issues involving alcohol (32%), anger (34%), gambling (22%), and abuse (39%).

Petry's (2003) study of 342 pathological gamblers compared those who had (41.8% were female) attended GA (38% were female) versus those who had never attended GA prior to initiating professional gambling treatment, found that more GA attendees received professional treatment for a psychological disorder (53% vs. 49%), experienced significant thoughts of suicide (50% vs. 33%) and, experienced significant thoughts of suicide in the past month (23% vs. 19%), compared to those who had not attended GA.

Collins, Skinner and Toneatto (2003) study of 4,565 individuals seeking substance abuse treatment found that 7% were identified at assessment as having gambling problems (screened as having some gambling problem or a pathological gambling problem). Among clients in the pathological gambling group (compared to clients identified as having some or no problem

gambling), 70% screened positive for another current Axis-I psychiatric disorder. A detailed review of client charts found that 19% of clients assessed as either having some gambling problem or a pathological gambling problem had gambling mentioned in their charts, 9% received gambling-related interventions, 5% were referred to specialized gambling treatment services at the time of assessment and 4% were referred during the course of their substance abuse treatment. The authors suggested that even if gambling problems were identified, they were perceived to be less significant when compared to concurrent substance abuse and psychiatric problems.

Finally, Petry, Stinson and Grant (2005) studied the prevalence and associations of lifetime pathological gambling and other lifetime psychiatric disorders among a large national U.S. sample. This study found the lifetime prevalence rate of pathological gambling was .42%. Among pathological gamblers 73% were alcohol abusers, 38% were drug abusers, 60% were nicotine dependent, 50% had a mood disorder, 41% had an anxiety disorder, and 61% had a personality disorder. Further, several DSM-IV psychiatric disorders were more strongly related to pathological gambling among women than men, including most of the substance use disorders, major depressive episode, and generalized anxiety disorder.

2.2 CONCEPTUALIZING BARRIERS

The concept of barriers to addiction treatment first appeared in the alcohol and drug abuse literature, and recently emerged as a topic of inquiry in the gambling field. Sources of potential barriers, suggested by the ecological model, include the following categories: individual issues, socio-environmental factors, and programmatic issues. The Center for Mental Health Services

Research at the University of Pittsburgh School Of Social Work operationalized the ecological approach to study treatment access, adherence, and effectiveness, in the following way:

Issues of access, engagement and adherence exist to varying degrees for all diagnostic categories, treatment settings, races, classes, age groups and cultures. They have an impact on the physical and mental well being of individuals and families. Our failure to connect patients with appropriate and needed care is related to unnecessary use of crisis services, primary and tertiary medical care, and expensive psychiatric hospitalizations. It prevents those who are distressed and in pain from resolving problems for which there are reasonable solutions and contributes to the chronicity of serious mental disorders. It is associated with stress and burden in families, and higher than necessary costs in providing both medical and psychiatric care. (Korr, 1998, p. 98)

The ecological systems perspective offers a way to bridge the gap between treatment and help seeking. The focus on the person and the environment explains a broader range of treatment barriers. The use of the ecological systems perspective in this study was primarily as an organizing framework. The ecological systems perspective views individual behavior as adaptive and in constant interchange with the psychological, biological, social, economic, and cultural elements of human experience (Barber, 1994; Gitterman & Germain, 1987; van Wormer, 1995). “For social workers, it is not just the addictive process that requires assessment and understanding; it is the totality of users’ lives, including all their interactions with the broader social environment. In other words, our model must look outwards to the social context of addictive behaviors, as well as inwards to the psychology of individual users” (Barber, 1994, p. 26). Therefore, it is the confluence of intrapersonal, interpersonal, social, cultural, environmental, and structural forces that may inhibit help seeking. The barriers assessed in this study are presented in a manner that reflects both the ecological systems perspective and the domains identified by Allen (1992).

2.2.1 Defining Barriers

Over two decades ago, researchers first attempted to understand the help-seeking behavior and the addiction change process of female drug addicts and alcoholics (Allen, 1992; Beckman, 1984; Beckman & Amaro, 1986; Beckman & Kocel, 1982; Cunningham, Sobell, Sobell, & Toneatto, 1992; Finkelstein, 1994; Grant, 1997; Melnyk, 1988; Schleibner, 1994; Schober & Annis, 1996; Thom, 1986; Vannicelli, 1984). Women were under-represented in alcoholism treatment programs, and Beckman contended that “women face many gender-specific barriers that may limit their access to alcoholism treatment” (1994, p. 208).

In 1992, the United States Department of Health and Human Services (USDHHS) acknowledged that for many women who were abusing alcohol and drugs “access ... to programs is limited by structural, economic, linguistic and cultural barriers (that) preclude provision of adequate services and thus limit the potential for controlling and reducing alcohol and drug abuse in the nation” (as cited in Allen, 1994, p. 430). Referring to the fit between clients and the health care system, Allen argued: “if it is affordable, acceptable and available, it is accessible” (1992, p. 11).

To define the construct of barriers, Allen (1992) integrated Melnyk’s (1988) definition of barriers as subjective phenomenon with Anderson’s Model of Health Service Utilization (1968), which defined barriers as external to the individual or objectively identifiable. Subjective phenomena include any beliefs or perceptions emanating from within the individual. External phenomena include features of the health care system, structural characteristics of programs, cultural factors, socio-environmental issues, or anything that constricts, restrains, or serves as an obstacle to the individual’s receiving help or treatment.

Allen (1992) recognized that several recurring themes emerged in the addictions literature and identified three broad domains. These domains are:

1. Individual characteristics including: gender; race; education; income; children; marital status; perceptions, beliefs, and attitudes about addiction treatment and health; and history of previous treatment experiences.
2. Socio-environmental issues including: family responsibilities; geographic location of facilities; family and friend social support; events leading to treatment seeking; community disincentives; and availability of treatment facilities.
3. Treatment program characteristics including: the costs of programs; attitudes of treatment staff; provider-consumer relationship; composition of staff; availability of support services like child care and transportation; gender and cultural relevancy in programming; aftercare support and vocational counseling.

From the major themes within these three broad domains, Allen (1992) developed the Allen Barriers to Treatment Instrument (ABTI). This scale was designed to identify treatment barriers among women addicts. Allen (1994) predicted that the ABTI could be used in “cross-cultural studies with people in various regions/countries concerned about the barriers issue” (p. 441). In Allen’s (1992) study of 97 alcohol and drug addicted women, the most frequently reported barriers for women were: role as a mother, wife and/or partner (55%); inability to pay for treatment (46%); and the lack of health insurance (45%).

2.2.2 Individual-level Issues

Individual-level issues include ideas, thoughts, beliefs, conditions, experiences or perceptions that may serve as potential obstacles to help seeking. These barriers include denial of the problem, feelings of guilt, shame or fear, concerns about lack of health insurance, and limited personal financial resources.

2.2.2.1 Denial

Denial acts as a barrier to getting help. Often, women deny they have a problem, instead perceiving their addiction as a coping mechanism for difficulties in their lives. Rather than seeking treatment for their addiction, they come to treatment reporting they are depressed, have medical problems, and/or are experiencing problems in their interpersonal relationships with their partner or child(ren) (Beckman, 1994). For problem gamblers, denial has been reported as being among one of the primary reasons for not getting help (Boughton & Brewster, 2002; Brown & Coventry, 1997; Evans & Delfabbro, 2005; Lesieur, 1987; Marotta, 1999). Lesieur's (1987) study of 50 female pathological gamblers from across the United States (all but one of whom was in GA) reinforced this notion. Among this sample, 34% sought help from a therapist prior to their involvement with GA without ever mentioning their gambling problem. While some women reported that they did not mention their gambling problem because they were not actively gambling at the time, others denied having gambling problems, and instead used therapy to address what they believed were more 'pressing' problems.

Brown and Coventry's (1997) study of 102 women who received assistance from a gambling help service found that 5% acknowledged they gambled and were concerned about their gambling, but denied their gambling was a problem. "Some of those callers that balked at the prospect of labeling themselves as 'having a problem' were nonetheless aware of the extent and nature of the problems they experience in association with their gambling activities" (p. 10).

Marotta's (1999) study of 29 naturally resolved former gamblers (31% were female) and 29 treated former gamblers (45% were female) found that the most frequently endorsed treatment barriers among respondents in the naturally resolved group were deciding to use one's own method (31%), denial and the minimization of a problem (28%) and embarrassment and /or anxiety (28%). Some reported that they did not consider themselves to be 'compulsive' or their problems severe enough to warrant treatment. No gender comparisons of barriers to treatment were calculated in this study.

Hodgins and el-Guebaly (2000) compared 43 resolved pathological gamblers with 63 active pathological gamblers. Among this sample, of which half were women, the majority (63% of the non-resolved and 53% of the resolved gamblers) never sought treatment for their gambling problem. Most (82%) reported that it was ‘considerably important’ to handle their gambling problem on their own and half denied having a problem or needing help.

The concept of denial as a treatment barrier was explored in Boughton and Brewster’s (2002) survey of 365 female gamblers from Ontario. Although psychological and emotional barriers prevailed as key barriers to treatment, almost three-quarters thought they ‘should’ make changes on their own and many (66%) thought they ‘could’ make changes on their own. These findings suggest not only ambivalence about making change, but also the tendency to be self-reliant and to resist formal treatment.

Finally, Evans and Delfabbro (2005) found the most significant barrier to seeking help related to personal attitudes which included: denial that a problem existed, a belief that the problem could be solved without external assistance, and an unwillingness to accept advice or stop gambling. Responses to the open-ended question “What did you see as major barriers in seeking help for your gambling problem?” revealed similar findings, with 50% reporting denial, pride and embarrassments as the key factor to no seeking help.

2.2.2.2 Feelings of guilt, shame, and fear

For women, the emotional consequences of gambling problems are often reported as feelings of guilt, shame, or fear (Lesieur & Blume, 1991). A woman's multiple societal roles within the context of family, work, and community may also influence the decision to avoid seeking help. “The gambling is often shrouded in secrecy and shame and women are reluctant to expose themselves through treatment” (Boughton & Brewster, 2002). As a wife/partner, mother, daughter, sister, or employee, admitting to having a gambling problem may cause a woman to feel ashamed and guilty. Custer (1985) suggested that a double standard exists for women

compared to men: the stigma and shame attached to excessive gambling is augmented by media bias in which the female problem gambler is often portrayed as the irresponsible Madonna. The female gamblers in Lesieur's (1987) study used their own and their family's money to support their gambling. These women depleted their savings, incurred debt, forged checks, and used government assistance to gamble. "Family possessions, savings and legitimate sources of funding are exhausted ... Obsession with getting out of trouble overtakes a desire for excitement as the principal motive for gambling" (Lesieur & Blume, 1991, p. 187). Lesieur and Blume (1991) suggested: "Women are acutely aware of the stigma applied by society to a woman who fails to meet the high moral standards expected of women placed on a pedestal. They feel both deeply ashamed and deeply resentful over the double stigma of being a compulsive gambler and of not having fulfilled their roles as moral models for society" (p. 190).

Brown and Coventry's (1997) analysis of 102 female callers to a gambling help-line found that 42% experienced guilt as a result of their gambling; respondents reported often lying about their gambling for fear of being found out. Women felt the lying associated with their gambling created problems in their relationships with family and friends. However, 14% reported that the embarrassment, guilt, and shame felt because of their gambling problem motivated them to get help.

Rich (1998) found most women were "defending against feelings of anger, guilt, shame, and sadness" (p. 96); yet, only 20% of this sample attended Gamblers Anonymous. Marotta (1999) suggested that "while shame is a commonly-reported feeling among addicted persons the magnitude of shame among problem gamblers may be greater than chemically dependent individuals...problem gambling may be more commonly viewed as a social and moral deficit" (p. 49). Marotta found that 28% of respondents endorsed embarrassment as the primary treatment barrier.

Hodgins and el-Guebaly (2000) found that embarrassment and pride were endorsed as important factors for not seeking treatment by half (50%) of their sample. The resolved

gamblers were more likely than the non-resolved gamblers to endorse embarrassment and pride as a constraint to help seeking (59% vs. 35%).

Several women from Berry, Fraehlich and Toderian's (2002) study attributed emotional concerns to their gambling behavior. In addition to feeling guilty, women reported lying about their gambling and neglecting relationships with family, partners, and children. They described experiencing a 'casino hangover' and feeling 'lousy' after gambling.

2.2.2.3 Concerns about health insurance coverage

Health insurance coverage is a critical factor in making health care accessible to women in the United States. The Henry J. Kaiser Family Foundation (2007) reported: "Cost pressures are increasingly acting as a barrier to health care – even for women with private insurance. In 2004, one in six privately insured women reported she postponed or went without needed care because she couldn't afford it, up from 2001." (p. 1) Svendsen (1998) reported to the National Research Council that all 34 National Council on Problem Gambling (NCPG) affiliates confirmed that most health insurers and managed care providers did not reimburse individuals receiving treatment from pathological gambling. The National Research Council (1999) concluded:

Such practices not only keep many from seeking treatment, but also require many of those who do seek treatment either to pay out of their own pocket – unlikely for a debt-ridden gambler – or to obtain coverage under the guise of another diagnosis often associated with pathological gambling, such as depression or substance abuse. (p. 212)

Most of the 34 affiliates of the NCPG received a small amount of funding from state or gambling industry organizations, and half of all affiliates supported treatment from public funding (Svendsen, 1998). In Minnesota, outpatient treatment shifted from a grant funded to a fee-for-service payment system July 1, 2000. The shift was enacted by the legislature to expand the availability and location of gambling treatment providers across the state and to be more

compatible with other methods of payment for health services (Minnesota Department of Human Services, 2007). In Oregon, the state funds outpatient, respite, and home-based minimal intervention. The majority of problem gambling clients were treated in outpatient settings (85.8%), followed by intensive outpatient/partial hospitalization (day hospital) (12.9%), minimal intervention (1.1%), and residential/inpatient (0.2%) (Oregon Department of Human Services, 2002).

In Canada, gambling treatment programs are government (provincially) funded, resulting in no fee for services and shorter waiting periods. The Ontario government dedicated 2% of gross slot machine revenue (\$3.5 million in fiscal 1998-1999; \$21.7 million in fiscal 2001-2002) to fund treatment, prevention, and research for problem gambling (Urbanoski & Rush, 2006). The 47 specialized problem gambling treatment programs in Ontario provide inpatient and outpatient community counseling and information services to problem gamblers and their family. Treatment and prevention programs are in place in most provinces. Yet, women continue to be under-represented in some of these programs. For Canadian women, other costs associated treatment such as child-care, travel, or time away from work inhibits access to services.

2.2.2.4 Lack of personal financial resources

Limited personal incomes and fewer financial resources may inhibit women's ability or desire to seek help for problems related to their gambling. Wiebe et al. (2006) found that problem gambling was strongly related to the amount of money spent on gambling. Prevalence data showed that individuals with severe gambling problems spent approximately 21% of their personal income on gambling compared to non-problem gamblers, who spent approximately 1.5%. Lower-income households spent proportionately more on gaming than higher-income households (Marshall as cited in Korn, 2000). A study conducted by the Canadian Tax

Foundation, which analyzed international and *Statistics Canada* data, found that spending on gambling tended to increase with age, but fell as education and income rose (as cited in Beauchesne, 2000, p. 10).

Women gamblers are reported to earn less than men, have less access to money and credit than men, and, as a result, end up in financial crisis sooner than men (Lesieur & Blume, 1991; National Council of Welfare, 1996; Potenza et al., 2001). Winning large sums of money motivated women to gamble in Berry, Fraehlich, and Toderian's (2002) study. The notion that a 'Big Win' would provide financial security is a predominant theme among those with limited financial resources. Grant and Kim (2002) found women reported spending a higher percentage of their annual income on gambling than men.

Gambling experts suggest that women experience problems associated with their gambling sooner than men because women are often at an economic disadvantage (Mark & Lesieur, 1992). Compared to the men, the female problem and pathological gamblers in Toneatto, Boughton, and Borsoi's (2002) study had higher rates of unemployment. This rapid progression into financial problems and problem gambling is referred to as telescoping in the gambling literature (Potenza et al., 2001). Potenza et al. (2001) found in their study that female problem gamblers, compared to their male counterparts, reported shorter periods of gambling despite similar periods of problem gambling before contacting the gambling help-line. In Australia, study participants in Rockloff and Schofield's (2004) study identified the costs associated with treatment as accounting for 7.7% of the variance. The gender of the 255 participants used in this analysis was not given although 49.7% of the overall sample were women.

2.2.3 Socio-environmental Factors

Women addicted to gambling experience treatment barriers in their social environment. Although these issues emanate from sources external to the woman gambler, they can be internalized and affect the decision to access treatment for a gambling addiction. Socio-environmental factors that may constrain gambling help seeking include societal stigma, lack of family and social supports, and socio-cultural factors.

2.2.3.1 Societal stigma

Up until the early 1990's there was little discussion about women gamblers and very few women sought help of any kind if they did have a gambling problem (Hulen & Burns, 2000). Early on, researchers in the field suggested that women gamblers faced societal disapproval because they “don't fit the male image of the gambler as big shot, big spender with a big ego” (Lesieur & Blume, 1991, p. 182). Lesieur and Blume (1991) recognized that “stigma, in addition to being single, separated or divorced, and having few social supports, are seen as factors that in combination produce the scarcity of females in GA and other treatment programs” (p. 183).

Custer and Milt stated that “society's attitude toward the female compulsive gambler is reprehensible” (1985, p. 149). They argued that a double standard existed: society held one standard for men and another for women. As a result, they found that female gamblers exhibited intense feelings of loathing and contempt when entering treatment programs. Custer and Milt (1985) offered the following insight:

Away from the track, casino or gaming room you may never know this woman does much gambling, let alone that she's got a gambling problem. She just will not talk about it. She's still living by society's rules and expectations and, in spite of the impact of the women's liberation movement, these are still generally different for women than they are for men ... A man can be 'a gambler,' and while this is not something to be admired, it is also not a cause for ostracism. People

may shake their heads and make some mild comments of disapproval when it's a man, but they manage to find a way to explain it, understand it, [and] tolerate it. But not so when it comes to a woman gambler. There is a quality of dissoluteness, immorality and indecency that people read into it, exceeding even that attributed to women alcoholics. (p. 147)

Hodgins and el-Guebaly (2000) suggested that the stigmatization of addiction problems contributed to people in their study wanting to handle the problem on their own. Over 80% of their study's non-treated participants believed they could stop gambling on their own without intervention. Crisp et al. (2000) suggested that the popularity of community-based treatment programs, such as *Break Even*, attracted women because they were located within existing agencies and provided discreet venues for women who were concerned about the perceptions of others regarding their gambling problem.

In Rockloff and Schofield's (2004) study, stigma accounted for 8.8% of the variance among the 255 participants experiencing at least 'some' gambling problem. Older respondents and men were statistically more likely to endorse the stigma factor. The 5 questions pertaining to stigma included: I would be embarrassed if a family member needed help with a gambling problem; people with a gambling problem lack self control; I would not want to be friends with someone who had a gambling problem; problem gambling treatment is only for persons with serious difficulties; and, a person who seeks treatment for a gambling problem may put their job in danger.

2.2.3.2 Lack of family and social supports

The problems associated with pathological gambling disrupt the family and the individual's social system. Referred to as 'closet gamblers' or 'loners,' some women gamblers remain isolated from their network of social supports (Lesieur & Blume, 1991). Grant and Kim (2002) found the majority of women gamblers (82%) gambled at slot machines because it involved no

social interaction. The hidden nature of women's gambling problems often results in family, friends, and co-workers being unaware that a gambling problem exists, or the extent to which gambling has become a problem, until it reaches a crisis. Often, family members force the gambler to seek treatment. However, once family and friends become aware of the magnitude of the lying, hiding of debts, or stealing that is often associated with gambling, they are left feeling angry and resentful, causing the woman gambler to feel more alone (Lesieur & Blume, 1991). This double-edged sword can further reinforce the decision to avoid seeking treatment or to deny that a problem exists.

Brown and Coventry (1997) found 26 (26%) of the 102 female callers in their study identified that their gambling behavior negatively effected their relationships. It is possible that gambling further eroded trust and exacerbated already troubled relationships for more women in this sample, given that 42% of callers reported resorting to lying and deception regarding their gambling.

2.2.4 Socio-cultural factors

Among individuals seeking help for a gambling problem, few come from ethnic or cultural minority backgrounds (Volberg & Steadman, 1989). In Ontario, the majority of women gamblers are Caucasian (Boughton & Brewster, 2002; Rush, Moxam, & Urbanoski, 2002). It is likely, even with available treatment services, that ethnicity and cultural norms and values preclude help seeking by women. Volberg and Steadman (1989) suggested that "the low enrollment of women and minorities in existing treatment programs was the result of Gamblers Anonymous being a primary referral source whose members tend to be predominantly middle-class, white men whose experiences and circumstances are different from those of women and non-white pathological gamblers" (p. 1619).

The under-representation of minority women in treatment programs may be the result of their perceptions and beliefs about mental illness and treatment, their religious beliefs, their degree of acculturation, or their level of English proficiency (Echeverry, 1997). Within patriarchal cultures, the fear and stigma associated with being ostracized from family and community for having a ‘problem’ may place enormous pressure on women to remain silent. Referring to the low utilization rates of Latinos and other minorities in mental health services, Echeverry (1997) suggested that “for many Latinos, emotional or mental problems are a sign of weakness, lack of strength or character, bad luck, the result of a spell or a similar supernatural event, or simply God’s will” (p. 99).

Urbanoski and Rush (2005) found the proportion of Caucasian women entering specialized gambling treatment programs increased during the study period from 81% (1998-1999) to 86% (2001-2002). The proportion of Aboriginal or First Nations (8.5% to 3.6%) and Asian (7.9% to 6.7%) women entering treatment decreased during the same period. The decrease in the number of non-Caucasian women entering specialized treatment programs raises further concerns about the unmet needs of minority groups regarding problem gambling treatment.

2.2.5 Programmatic Characteristics

Program characteristics pertain to the organizational, institutional, or structural elements of treatment programs. These characteristics are external to the female gambler; yet, they act as barriers and inhibit women from accessing help for their gambling problem. Program characteristics included the lack of women-sensitive interventions, the inadequate training of health care professionals, and the lack of public understanding of gambling treatment programs.

2.2.5.1 Lack of women-sensitive treatment programs

Women-sensitive gambling treatment programs are clearly the exception. Gambling treatment programs were designed to meet the needs of the male gambler (Mark & Lesieur, 1992). Today in gambling treatment programs, men and women generally receive treatment together. The lack of women-sensitive or women-specific treatment programs inhibits the recruitment and retention of women because of the treatment program's inability to satisfy the unique needs of women (Mark & Lesieur, 1992). For over twenty years, the substance abuse literature recognized a need for gender specific treatment and encouraged treatment programs and helping professionals to be sensitive to women's issues provide services that were nurturing, supportive and empowering (Beckman & Kocel, 1982; Ministry of Health and Long Term Care, 2005; Schliebner, 1994). The Ontario Substance Abuse Bureau (1996) emphasized the importance of recognizing gender difference in planning services for women:

Women's experiences differ from men's, in substance use as in the wider social context. These differences have implications for treatment planning if women are to access services on an equitable basis and have an equal chance for positive outcome. (p. 1)

The current rates of gambling treatment utilization among female problem gamblers suggest that possibly women are reluctant to access services because existing services are not what they want or are perceived of not meeting their needs (Boughton & Brewster, 2002; Rush, Moxam & Urbanoski, 2002). Boughton & Brewster (2002) found that the women in their study were highly self-reliant and strongly believed that they should control their gambling without help, yet, reported wanting written materials to help them understand their gambling problem and self-directed strategies for change. The fear associated with being judged and criticized lead to embarrassment and shame and a reluctance to seek professional help. Hulen and Burns (2000) suggested that many women who do seek help for gambling problems choose not to stay in recovery programs because of gender-specific issues. Berry, Fraehlich and Toderian (2002)

argued that treatment strategies need to pay special attention to women-specific issues. The women in their study identified specific aspects of treatment that were important including female counselors, ensuring confidentiality, providing child-care, increasing the hours of services to accommodate, providing faster services, more in-depth counseling and housing gambling treatment services in community health centers to reduce stigma.

Lesieur and Blume (1991) recognized that “the depth of guilt and shame in the female patient requires special attention...the female patient must be helped to establish enough self-esteem to feel worthy of recovery, and to care enough about the future to expend the necessary effort” (p. 193). Twenty-two percent of women in Lesieur’s (1987) study reported that gender-specific issues, including relationship problems, sexual activity, sexual harassment and sexual advances by male GA members were “often overlooked” in the GA meetings.

2.2.5.2 Inadequate training of health care professionals

It is inevitable for social workers to have contact with women who have a gambling problem.

Social workers are in an ideal position to facilitate primary prevention (promote health before problems begin) and secondary prevention (screening, identification, and brief intervention when problems are in the early stages and have not progressed into full-blown conditions), as well as tertiary prevention (treatment of the full-blown condition) and rehabilitation (intervention designed to limit the debilitation caused by the chronic condition). (Amodeo, 1997, p. 552)

Chacko, Palmer, Gorey, and Butler (1997) interviewed 20 human service professionals from a cross-section of social services, and although no formal measure to assess gambling was used, they estimated that gambling problems were prevalent in 20% of caseloads. Yet, few social workers receive any type of gambling addictions training. Shaffer, Hall, and Vander Bilt (1995) concluded that the majority of professional staff at 237 New England licensed substance abuse treatment facilities reported having very little or no knowledge of pathological gambling.

Seventy percent of women in Lesieur's study sought help from a mental health professional prior to Gamblers Anonymous, but they were rarely asked questions about their gambling problems (Mark & Lesieur, 1992). "Knowledgeable professionals have a real opportunity to intervene with these suffering patients ... unfortunately, the vast majority of therapists either failed to recognize the gambling problem or failed to intervene effectively" (Lesieur & Blume, 1991, p. 189). Dell, Ruzicka, and Palisi (1981) suggested that unlike the alcohol or drug addicted client, who may experience physical symptoms, gambling problems may be more difficult for the health care professional to recognize and diagnose because they are rarely accompanied by physical symptoms. Brown and Coventry (1997) found that health professionals and psychologists were reported to be the least helpful source of support for the 102 women gamblers who called their service.

More recently, Collins, Skinner, and Toneatto's (2003) study of the impact on treatment of concurrent pathological gambling and other Axis-I disorders in an addiction treatment setting, raised specific questions regarding how clients with complex problems are treated when they seek help. This study is relevant to our understanding of comorbid disorders as well as having implications for the identification, assessment, and treatment of pathological gambling as a comorbidity among clients seeking substance use and mental health treatment. Collins et al. found that the majority of clients screened for problem and pathological gambling did not receive treatment that was specifically focused on problem gambling. "Beyond assessment, gambling problems either blended into the larger profile of addiction issues or were simply ignored" (p. 3). They recommended that addiction and mental health service professionals should receive training for the screening, assessment and treatment of pathological gambling.

Over twenty years ago, Sandmaier (1980) criticized doctors and therapists for their perception of women alcoholics and drug addicts, believing that health professionals at that time were inadequately trained about addictions. She wrote:

Most of the women whom I interviewed recovered from alcoholism in the face of an appalling lack of support from the doctors, therapists, alcoholism personnel,

and others charged with diagnosing and treating their illness...They discovered what most alcoholic women who seek help are forced to recognize: that contemptuous attitudes and sheer ignorance about women with alcohol problems pervade the health system as thoroughly and destructively as any other segment of society. There, as anywhere, the real needs and the very humanity of alcoholic woman remain invisible. (p. 26)

This critique can be applied today with the substitution of the word “gambling” for “drugs and alcohol.” Social workers lack the knowledge and training to help gambling addicted clients. The continued debate over the causes of pathological gambling may also contribute to its slow acceptance in some professional communities. Although the disease model that sees gambling as an addictive disorder is pervasive and most widely used by researchers and treatment providers, the diagnostic criteria for pathological gambling have been questioned and some “have argued that pathological gamblers do not really experience irresistible impulses and that they retain control over their behavior” (Murray, 1993, p. 803). Supporters of the disease model argue that addiction exists without taking a drug; the addiction in this instance is to the action of gambling (Blume, 1987). Ferris, Wynne, and Single (1999) noted “research reveals a certain amount of consensus, with most scholars agreeing that gambling problems may be conceptualized as the result of a combination of biological, psychological and social factors” (p. 1).

2.2.5.3 Awareness of gambling services

Most people in Ontario are unaware of gambling treatment services (Wiebe, Single, & Falkowski-Ham, 2001). Wiebe, Single, and Falkowski-Ham (2001) studied the prevalence of gambling problems in Ontario and explored the awareness of non-gamblers, non-problem gamblers, at-risk gamblers, and moderate gamblers to gambling services. While those with severe gambling problems were the most likely group (compared to non-gamblers, non-problem gamblers, at-risk gamblers, and moderate gamblers) to be aware of counseling services, a significant percentage of gamblers, regardless of ‘type’ were unaware of Ontario’s toll-free gambling help-line and counseling services. Rush et al. (2005) suggested that treatment capacity

and community awareness of treatment availability should expand at a rate that is proportionate to gambling expansion. Rush et al. (2005) found that individuals living in close proximity to a gambling venue were more likely to be in treatment if they were also close to a treatment program.

A key treatment barrier identified in Boughton and Brewster's (2002) study was the lack of accurate information about gambling treatment services in Ontario. Boughton and Brewster (2002) found that 57% of study participants had misconceptions about treatment, such as believing that treatment would require them to abstain from gambling completely when they didn't want to. Almost half (46%) believed that treatment was only available for those with the most severe problems, while less than half (41%) reported not knowing what to expect from treatment. Finally, over one-third (38%) reported being unaware of the availability of treatment services.

2.3 SUMMARY

Researchers suggest that women with a gambling problem are an under-served group, often 'under-represented' in gambling treatment programs (Boughton & Brewster, 2002; Lesieur & Blume, 1991; Rush et al., 2005; Rush, Moxam & Urbanoski, 2001; Urbanoski & Rush, 2006). Currently, gambling treatment is available and provided in a variety of ways. Often, treatment programs utilize multi-method approaches that offer a full range of services to address diverse client needs. However, barriers to treatment, including individual, socio-environmental and programmatic issues, may prevent women from seeking treatment and, ultimately, limit their potential for recovery from a gambling

addiction. Unless treated, pathological gambling can compromise, disrupt, and possibly destroy one's personal, social, and professional life.

Social work's ecological systems perspective offers a comprehensive framework for understanding treatment barriers and allows for the barriers construct to be expanded and conceptualized in a unique way. From this perspective, treatment barriers are understood within the context of intrapersonal, interpersonal, socio-environmental and structural influences that can interfere with help seeking. The literature reveals that, for some, the fear, guilt or shame associated with a gambling problem may result in denying that a problem exists. Not knowing what help is available or believing that their problem is merely a financial one can leave women feeling ashamed and alone, as well as facing untold financial problems. Socio-environmental factors, such as lack of social supports, lack of financial resources, and societal stigma, also create barriers that can constrain women's help seeking. Treatment that is intended to develop new coping skills and promote positive patterns of behavior can also be hindered by such programmatic issues as the lack of women-sensitive treatment programs and the inadequate training of health care professionals in diagnosing and treating gambling problems.

3.0 METHODOLOGY

This descriptive study examined the question: What are the barriers to treatment experienced by a sample of women gamblers? More specifically, this research assessed the individual issues, socio-environmental factors, and treatment program characteristics that deter women problem gamblers from getting help. Second, this study compared the barriers to treatment identified by women who were and were not actively involved with Gamblers Anonymous. Third, this study compared the barriers to treatment identified by women who received and did not receive formal help. Finally, this study compared the responses obtained by the two data collection methods: paper and pencil format versus email format.

I used a cross-sectional survey design in this study. Self-reported retrospective data regarding treatment barriers, severity of gambling problems, personal and family history of addiction, and treatment experiences were obtained.

This chapter begins by describing the study participants and the sample recruitment strategies used. This chapter also describes the instruments and variables, the data analysis approach employed, and the steps taken to protect human subjects.

3.1 STUDY PARTICIPANTS

The women in this study were selected using the non-probability method of purposive sampling. Specifically, the target population from which data were gathered were women, 18 years of age

or older, who self-identified as having a gambling problem and were a member of Gamblers Anonymous (GA) or participated online in the gambling self-help forum Compulsive Gambling Hub (CGHub). A total of 101 respondents were recruited, resulting in 90 usable questionnaires, and these women can be thought of as constituting two groups.

Group 1 consists of women involved with GA in cities across southwestern Ontario and southwestern Michigan. These cities, particularly Windsor, Detroit, and Toronto, were selected because of their proximity to casinos and a variety of other gambling venues. Women living in these areas may be likely to experience problems if they gamble; prevalence data suggest that the availability and accessibility of gambling venues contribute to increased rates of gambling-related problems in the general population, and, more specifically, increased levels of gambling participation and gambling problems among women from the Windsor area (Frisch, Govoni & Rupcich, 1999).

Group 2 consists of women recruited from CGHub, an online self-help gambling forum. This site allows individuals to communicate online with people who are experiencing similar problems. Online forums can replace or supplement professional forms of treatment (Finn & Lavitt, 1994). Finn (1995) suggested:

[it] is not uncommon for members of one helping modality to participate in another. In some cases, membership in one type of group (e.g. support) leads to information and support which prompts membership in another group (e.g. treatment). In other cases, support and self-help/mutual aid groups have been used as a transition from treatment groups, providing on-going support and follow-up to group treatment in still other instances, members may belong to more than one type of group simultaneously. (p. 111)

CGHub was selected based on my observation of this site; the daily postings and the level of activity suggested that the site was active and popular among compulsive gamblers, particularly women. CGHub is similar to other online self-help forums that are

monitored by individuals, who are the self-appointed originators of the group and who volunteer their time to moderate discussions and assure that there is no abusive or inappropriate language.

3.2 SAMPLE RECRUITMENT

Group 1 was recruited using a variety of strategies. First, participants were recruited from GA meetings in cities across southwestern Ontario and southwestern Michigan from July 2002 until June 2003. I contacted key GA members in Windsor and Detroit and informed them of my study and the need for involvement by women from GA. In turn, these key GA members contacted meeting leaders in several cities and obtained permission for me to attend specific GA meetings (see Appendix A - Principal Investigator's Initial Contact Script for Recruitment at Gamblers Anonymous). I was an invited guest, and key GA members attended the meetings with me.

At the start of each meeting I announced that I did not have a gambling problem and was not attending the meeting because of my desire to stop gambling. I verbally described the purpose of the study, what the study involved, summarized the risks and benefits of participation, explained participants' rights in the research, the anonymity of the information, and the voluntary nature of participation. This information was also presented in writing to each potential participant (see Appendix B - Principal Investigator's Script for Introducing Study and Informing Participants at the Gamblers Anonymous Meetings).

Participants were instructed to return either the completed questionnaire, sealed in a manila envelope, to me or the key GA member, or to mail the questionnaire to the return address on the envelope. American or Canadian postage (depending on where the meeting was taking place) and U.S. Customs Tracking Labels (for packages mailed from the U.S.) were provided for participants wanting to mail the questionnaire. Participants were instructed not to put their return

address on the envelope. This method was used successfully by Getty, Watson, and Frisch (2000) to recruit Gamblers Anonymous members.

To increase the number of participants, I received permission from the Director of the Michigan Council on Problem Gambling and the Gamblers Anonymous Inter-group Leaders for Michigan and Toronto to attend and recruit participants at the Gamblers Anonymous mini-conferences that were held in Livonia, Michigan, August 16-18, 2002, and Toronto, Canada, October 4-6, 2002. These conferences were open to 'members,' 'family,' and 'friends' of Gamblers Anonymous, and attracted people from across southwestern Ontario and Michigan. My attendance was announced at registration and at the start of the conference. During registration, women interested in participating in the study were given a study package. The study package included the introductory letter, the questionnaire, and a self-addressed, stamped manila envelope. The letter explained the purpose of the study, what the study involved, the risks and benefits of participation, and participant rights as a research subject. Potential participants were advised that all information obtained was completely anonymous. The letter advised participants to return the questionnaires to the 'questionnaire deposit box' or mail them to the return address on the envelope (see Appendix C - Principal Investigator's Script for Introducing Study and Informing Participants at the Gamblers Anonymous Mini-Conferences). American or Canadian postage and U.S. Customs Tracking Labels were provided to participants.

In a final effort to recruit participants for Group 1, key GA members, including the Director of the Michigan Council on Compulsive Gambling and the Public Relations Representative for the Windsor/Detroit Region, were asked to distribute questionnaires to women in GA. The study packages included the introductory letter, the questionnaire, and a manila envelope with the return address and postage (see Appendix D - Principal Investigator's Script for Introducing Study and Informing Participants from Referrals from Key Members of Gamblers Anonymous). Participants were instructed to return completed questionnaires in the sealed manila envelope to the key GA member or to mail them to the return address. These

various efforts resulted in 72 questionnaires being returned. Sixty-four of these questionnaires were usable and were included in the data analysis.

Group 2 (email sample) was recruited via the Internet at the gambling self-help site CGHub. To recruit these potential participants, on October 29, 2002, I posted an introductory message that described the purpose of the study, the risks and benefits associated with participation, the rights of the research participant, and the anonymity of the information obtained. Since the posting of messages occurs daily, this message was posted every day until no further email responses were being received (see Appendix E - Principal Investigator's Script for Email Recruitment, Introducing the Study, and Informing Participants). As with mail surveys, email surveys require multiple contacts to increase response rates (Mehta & Sivadas, 1995; Smith, 1997; Schaefer & Dillman, 1998).

To protect their identities, potential email participants were encouraged to obtain a free web-based email account from a provider such as Hotmail or Yahoo and to sign in using either a pseudo name or their first name and the first initial of their last name in keeping with the tradition of GA. If interested in participating, potential participants were instructed to send an email to treatmentbarriers@hotmail.com indicating their willingness to participate. All interested participants were emailed the questionnaire.

Email participants were given the option of completing the self-report questionnaire via email or printing the questionnaire, completing it as a hard (paper) copy and, mailing it back to the study's address. Given the expense associated with mailing the survey, none of the email respondents selected this option. Participants returning completed questionnaires to the email address were advised that an 'honest broker' was being used for this study to further safeguard anonymity. The honest broker was a key member of the GA community and had no interest in this study except to act as an intermediary between the participants and me to ensure participants' anonymity. The honest broker retrieved completed questionnaires and corresponding email addresses from the study's email address, separated respondents' email addresses from their questionnaires and provided me with the questionnaires only, destroying the

email addresses. A total of 35 women were recruited from CGHub. Twenty-nine women completed the email version of the questionnaire; none chose to print it and mail it back. Twenty-six of these questionnaires were complete enough to be used in the analysis.

3.3 INSTRUMENT AND VARIABLES

The instrument for this study consisted of a self-report questionnaire that included both closed-ended and open-ended questions. The questionnaire contained sections on demographics, personal and family history of addictions and mental health, gambling severity, and treatment issues. The South Oaks Gambling Screen (SOGS) and the Gamblers Anonymous 20 (GA20) Questions scales were used to measure gambling severity. The Allen Barriers to Treatment Instrument (ABTI) scale was used to measure barriers to treatment. Permission to use these scales was obtained (see Appendices I and J).

The instrument was reviewed by an expert panel consisting of two members of Gamblers Anonymous (both abstinent for over 5 years), and a sociologist, who had expertise in the field of gambling addiction and who trained and certified professionals as gambling counselors. The panel members found the instrument to be appropriate. One member suggested that the first open-ended question, which was “Why do you (or did you) gamble?,” be changed to ‘What does gambling do for you?’

The instrument appeared in two formats: paper-and-pencil/administered version (method 1) (see Appendix F - Administered Questionnaire), and email version (method 2) (see Appendix G - Email Questionnaire). The two versions of the questionnaire were designed to be as similar as possible to each other, with the paper version created first. Schaefer and Dillman (1998) recommended this strategy and stressed that “by using a familiar format, the cognitive burden placed on the respondent is reduced” (p. 6). For example, text on the paper version has a

maximum line length of 80 characters, compared to 60 characters on the email version to ensure that the lines of text would not wrap around. Circling an answer or checking a box are also impossible options for email formats; therefore, a response box “[]” was created next to each answer choice for pre-coded questions to allow respondents to place an “X” in the appropriate box.

The email survey had an embedded ASCII text design rather than an attached format, as recommended by Couper and Crawford (2000). The embedded format has few compatibility problems and allows the respondent to scroll through all the questions, respond, and email the message back to the sender when completed. The disadvantage of this format is that it is limited by its basic style and design options; for example, there are no skips, branching, fills, conditional questions, text enhancements, or graphical images (Couper, 2000). “This approach is largely system-independent (the message can be read with any software/ hardware combination) and it is the closest equivalent to a traditional mail survey, with all the benefits and drawbacks that such a design brings” (Couper, Blair, & Triplett, 1999, p. 44). The embedded format also was selected because research has found a higher response rate for the embedded format compared to the attached format (37% vs. 8%) (Dommeyer & Moriarty, 2000).

3.3.1 Demographics

Participants were asked to self-report specific demographic information including age, race, occupation, number of dependents, marital status, education level, income, and residence. The variables personal income, employment status, marital status, and ethnicity were recoded into new variables to achieve an expected frequency of 5 or greater in all cells (an assumption of chi-square analysis). These new variables were used for all analyses and were recoded in the following way: new personal income was recoded as “1” = \$0 to \$14,999, “2” = \$15,000 to \$34,999, “3” = \$35,000 to \$59,999, and “4” = \$60,000+; new employment status as “1” =

employed and “2” = unemployed; new marital status as “1” = currently married and “2” = not currently married; and ethnicity as “1”: = Caucasian and “2” = non-Caucasian.

3.3.2 Gambling Severity

Gambling severity was measured using the South Oaks Gambling Screen (original version) and the Gamblers Anonymous 20 Questions. Lesieur and Blume (1987) developed the South Oaks Gambling Screen (SOGS) (Appendix F). It is a 20-item scale that is based on DSM-III and DSM-III-R diagnostic criteria and is used to screen for pathological gambling. The SOGS asks subjects about their gambling activity and associated behavior throughout their lifetime (Battersby, Thomas, Tolchard, & Esterman, 2002). The SOGS asks questions about lying and hiding evidence of gambling; spending more time or money than intended on gambling; arguing with family members about gambling; feeling guilty about gambling; wanting to stop gambling but being unable to; losing time from work to gamble; and borrowing money, selling possessions, or passing bad checks to gamble or to pay gambling debts. The original SOGS does not differentiate pathological gamblers who are abstinent from those who are actively gambling (Govoni, Frisch & Stinchfield, 2001).

Although the SOGS was developed for use in clinical settings, it is a widely used instrument among general population samples (Ferris, Wynne, & Single, 1999). The SOGS has demonstrated satisfactory reliability and validity with four different samples, including Gamblers Anonymous, university students, psychiatric hospital patients, and hospital employees (Lesieur & Blume, 1997). The coefficient alpha for the scale in this study was .76, demonstrating high internal consistency. The SOGS is scored by adding up the number of questions that show ‘at risk’ responses (Lesieur & Blume, 1987). A respondent who answers ‘yes’ to five or more of the 20 items is regarded as a probable pathological gambler (PPG) (Lesieur & Blume, 1987). Scores

of one through four indicate the presence of problems associated with gambling. This study used total scale scores for the analyses.

The Gamblers Anonymous 20 (GA20) Questions was developed in 1984 and is comprised of 20 dichotomous (yes/no) questions (Appendix F). The questions were derived from the experiences of GA members (Derevinsky & Gupta, 2000; Lesieur & Blume, 1987). The GA20 is scored by summing the number of items endorsed out of 20, and a score of 7 identifies an individual as a compulsive gambler (Gamblers Anonymous, 1984). For this study, total scale scores were used for the analyses.

The 20 questions address the impacts of gambling across three dimensions: personal, social, and financial. Personal effects of gambling include gambling to escape worry, frustration or disappointment, having difficulty sleeping, feeling remorse, and considering self-destruction because of gambling. Social effects of gambling include an unhappy home life, damage to one's reputation, and loss of time from work, carelessness about the welfare of self or others, gambling longer than intended, and celebrating good fortune by gambling. The financial effects of gambling include borrowing money to gamble, spending your last dollar, selling property to finance gambling, committing illegal acts and returning to gamble to win back losses.

Little data about the psychometric properties of this scale are available. In Spain, Ursua and Uribe Larrea (1998) administered a Spanish version of the GA20 to a sample of 127 problem gamblers and 142 non-pathological or social gamblers and found the GA20 to be highly reliable ($\alpha = 0.94$) and valid. They found that one factor explained more than 50% of the variance and its diagnostic efficacy was 98.8% (which was attributed to its one-dimensional structure that included 17 of the 20 questions.) The coefficient alpha for this scale in this study was .83, demonstrating high internal consistency.

3.3.3 Gambling specific issues

For descriptive purposes additional information regarding the respondents' overall experience with gambling was obtained through three closed- and three open-ended questions. The closed-ended questions asked respondents about the length of time they gambled, the length of time gambling had affected their lives in negative ways, and the last time they gambled. The open-ended questions section asked the respondents about what gambling does for them respondent, why the respondents had not stopped gambling (if they indicated in an earlier question that they had not stopped gambling), and what problems gambling has caused in their life.

3.3.4 Formal and informal help

To better understand the help-seeking behavior of participants, a series of closed- and open-ended questions pertaining to the participants' involvement in a range of formal and informal treatment services and supports were included. The 11 closed-ended questions elicited information about personal history of formal and informal gambling treatment and support. Participants responded with a 'yes' or 'no' answer to 'wanting,' 'trying,' and 'receiving' various treatment options. Formal treatment and support included residential, outpatient, psychiatric or medical, counseling or therapy, crisis hot line, and 'other' formal services. Informal treatment and support included GA, Internet self-help, support from family and friends, and 'other' informal services.

Information about the respondents' current level of involvement in GA was obtained by asking what 'Step' they were on. Responses ranged from No Step to Step 12. Respondents were also asked to respond to two dichotomous (yes/no) questions about whether or not formal treatment had been helpful and whether or not informal treatment had been helpful. For these

two questions, respondents were then asked to provide a narrative response to embellish their answer.

Also included in this section on formal and informal treatment were questions pertaining to family issues related to gambling. Respondents were asked, with either a 'yes' or 'no' response, if their spouse or partner supported them getting help. Respondents who answered 'no' to this question were asked to explain why their spouse or partner did not support them. Respondents were also asked who else in their life has or had a gambling problem. The participants responded 'yes' or 'no' to eight items that asked about their father, mother, brother or sister, grandparent, partner, child or children, another relative, or a friend or someone important in their life.

3.3.5 Mental health and addiction history

Questions in this section pertained to other emotional, psychological, or addictive disorders and were derived from the emotional sub-section of the SOGS-PLUS (Lesieur & Blume as cited in Ferris, Wynne, & Single, 1999). Participants were asked if they received treatment for any emotional, psychological, or addictive disorder, other than gambling. If the participant responded 'yes' they were asked to identify what they had been treated for and if what they had been treated for was related to gambling and or drug or alcohol use.

Participants also were asked if their gambling problem surfaced during the course of other treatment. Respondents were asked, as well, if they had ever felt seriously depressed and if their depression was related to their gambling and/or drug or alcohol use. Finally, in this section, participants were asked if they had ever attempted suicide and if their suicide attempt was related to gambling and/or drug or alcohol use.

3.3.6 Treatment barriers

The questions relating to treatment barriers were derived and adapted from the Allen Barriers to Treatment Instrument (ABTI) (1992). The ABTI is a 30-item, self-administered scale. It was designed to identify barriers to treatment by those who are experiencing or have experienced a problem with alcohol or drug abuse (Allen, 1992). In addition to providing a means for addicted women to identify the factors that keep them from seeking the treatment needed to address certain health problems, it also offers a tool to researchers in the form of a standardized instrument for identifying barriers to treatment for addicted women (Allen, 1992; Allen & Dixon, 1994). I adapted the ABTI for this study by making ‘gambling,’ rather than drug or alcohol terminology, the referent for the items. For example, the word ‘gambling’ was added to the words ‘addicted female.’ The words ‘sober,’ ‘alcohol-free,’ and ‘drug-free’ were replaced with the word ‘abstinent.’ As well, the words ‘alcoholic,’ ‘drinking,’ ‘drug-abusing,’ and ‘drug-use’ were replaced with the word ‘gambling.’ Also, based on the review of the gambling literature, three barrier items were added and one was removed, allowing participants in this study to respond to 32 barrier items (these new items will be discussed below) (Appendix F). Responses to barriers items were: 0 = not at all, 1 = a little, 2 = somewhat, and 3 = a lot.

Allen (1992) assessed the psychometric properties of the original 30-item self-report scale with two samples of addicted women. The first sample (97 subjects not in treatment) was used for testing internal consistency reliability and dimensionality, while the second sample (35 subjects in treatment) was used to test for criterion-related validity. Barriers to treatment encompassed three broad dimensions: treatment program characteristics; personal beliefs, feelings and thoughts; and socio-environmental issues. Allen concluded that the ABTI showed “good reliability and validity as a standardized instrument measuring barriers to treatment faced by addicted women” (1994, p. 561).

In Allen's study the reliability of the overall ABTI and the subscales was calculated using Cronbach's alpha. Allen found the ABTI to be internally consistent with an $\alpha = .87$. The Cronbach's alpha for the scale in this current study was .88, suggesting high internal consistency. Allen found the three subscales to also be reliable. Subscale 1, treatment program characteristics (TPC), had an alpha of .84; subscale 2, individual beliefs, feelings and thoughts (PBFT), had an alpha of .67; and subscale 3, socio-environmental issues (I), had an alpha of .75. Each subscale and the reliability coefficient obtained is discussed below.

The questions in the individual issues section pertained to individual feelings of shame about addiction, abstinence, financial issues and health insurance to cover costs of treatment, trust in professionals, denial of problem and help, and role responsibilities. In my study, this section included 11 items in contrast to Allen's (1992) 10 items. The question 'I have religious beliefs about this problem' originally used by Allen (1992) was eliminated based on the recommendation of the expert panel who reviewed my draft questionnaire. The two questions that I added were: 'feeling lonely without gambling in my life, has kept me from getting help'; and 'being afraid of what people will think of me if I get help for my gambling has kept me from getting help.' The individual beliefs, feelings and thoughts subscale obtained an alpha of .79 in the current study.

The section on socio-cultural and environmental issues included 10 items; no items were added to or deleted from the original subscale. These questions obtained data about family and friend social support, acceptance and protection, availability of child care, community disincentives, conflict with partner/spouse, work-related issues, fear of losing custody of children, and stress-related issues. The socio-environmental subscale had an alpha coefficient of .70 in the current study.

Questions pertaining to treatment program characteristics consisted of 11 items, compared to the 10 items used by Allen (1992). These questions assessed treatment knowledge, program availability and accessibility, treatment staff attitudes, staff composition and gender relevancy in programming, availability of support services like transportation, aftercare support,

and organizational confidence. I modified the wording of two questions from Allen's (1992) original scale: 'not knowing the location of treatment programs,' was changed to 'not knowing what help is available in my area;' and 'no help from treatment programs for staying alcohol free and/or drug free afterwards' was changed to 'no treatment follow-up from formal treatment programs to stay abstinent.' I also added the following question to this section: 'the lack of knowledge about gambling problems from staff in formal treatment programs.' The treatment program characteristics subscale obtained an alpha coefficient of .78 in the current study.

3.4 DATA ANALYSIS

3.4.1 Data Preparation

For the numeric data collected, a database was created using SPSS version 11.0. The data were entered directly into the computer from each instrument. Frequency distributions were computed on all variables to visually check for data entry errors. Any errors found were compared with the original questionnaire and corrected.

The responses to all open-ended questions were examined using content analysis. The categories that emerged from the content analyses were used to develop coding for the open-ended questions. The coding scheme was evaluated for reliability by comparing my coding with that of an independent coder. Every third case (n=30) was selected and coded by the independent rater. The comparison between raters ranged from 80% to 100% for all categories.

3.4.2 Analytic Procedures

Both descriptive and inferential statistics were produced for the quantitative data. Descriptive statistics (including means, frequencies, etc.) were analyzed and reported. T-tests and one-way analyses of variance (ANOVA's) were performed to examine bivariate relationships between continuous and categorical variables. Categorical data were analyzed with Chi-square statistic (χ^2). Scale data were analyzed using the Pearson product moment correlation.

Qualitative analysis of the open-ended items was undertaken, and included identifying themes or patterns in the narrative data that represent potential response categories for the variable (Engel & Schutt, 2005). These responses provided for more in-depth information. Responses were coded into categories constructed from the review of all open-ended item responses, and, as such, the unit of analysis was a phrase, sentence, or paragraph that expresses one thought or idea in relation to the question asked.

3.5 PROTECTION OF HUMAN SUBJECTS

For members of GA, anonymity is paramount, especially when faced with the potentially devastating consequences of their gambling addiction. Therefore, particular attention was given to sensitive information and great care was taken to safeguard the anonymity of respondents. An Introductory Letter (Appendices B, C, D and E) was given to all potential participants prior to their filling out the questionnaire. The letter explained the purpose of the study, what the study involved, the risks and benefits of participation, and participant rights as a research subject. Potential participants were advised that all information obtained was completely anonymous.

An ‘honest broker’ was used for the email participants to afford further protection. The honest broker had no interest in the study and served as a “disinterested intermediary between the researcher and the individual whose data are being studied ... and ensures that the investigator is not interacting with those individuals nor recording any identifiable information about them” (IRB Research Protocol Exempt Research, www.irb.pitt.edu/Exempt/honestbroker).

Participation in this study was based on voluntary and informed consent. All participants were adults capable of giving voluntary informed consent to participate. This research was reviewed and received exempt status by the Institutional Review Board (IRB), University of Pittsburgh (IRB # 020841). A signed informed consent form was not required given the anonymous nature of this study and the fact that participation in it posed no more than minimal risk. The email address of my dissertation chairman was included in the Introductory Letter as a way of adding credibility to the study. Finally, as per the University of Pittsburgh’s IRB protocol, all surveys will remain in my possession in a locked file for a minimum of five years

3.5.1 Confidentiality

All efforts were made to respect participants’ rights to privacy and to safeguard the confidentiality of the information provided electronically. Since there is no legal protection of email privacy, “confidentiality with email surveys relies on the researcher’s assurances” (Schaefer & Dillman, 1998, p. 382). All available precautions were taken for this study. The information gathered from the surveys was viewed only by me and the honest broker. All surveys completed by email were separated from their corresponding email address and then made into hard (paper) copy by the honest broker. Once a hard copy was made of the email

questionnaire, the corresponding email address and the questionnaire were deleted from the computer's hard drive so that no record linking the questionnaire with an email address existed.

3.5.2 Anonymity

Every precaution was taken to ensure anonymity. No completed survey was identified with the respondent's name or any other identifying information. Identification numbers or linkage codes were not used and, therefore, there was no identifying information in the data code book or stored on the computer. At the GA meetings and at the mini-conferences, surveys were distributed to all women interested in participating, and all prospective participants were provided with a self-sealing manila envelope for returning the questionnaire. I was not able to discern who completed a questionnaire and who did not.

Email participants were advised to respond to my request to participate in this study using a pseudo name from one of the free Internet email providers such as Yahoo or Hotmail. Specific instructions on how to obtain a new, anonymous email account were given to email participants in the Introductory Email Letter. The honest broker was responsible for ensuring the anonymity of email respondents by separating from the questionnaire any identifying information that might link the participant to the study.

3.5.3 Risk and benefits

The potential risks to participants were minimal and were no greater in and of themselves than those ordinarily encountered in daily life. Any risks were described in the Introductory Letter. However, because feelings of fear, shame and guilt have been attributed to women gamblers, participants might have felt some discomfort in writing about their gambling addiction. Participants may have feared revealing too much information about their gambling problem or

that people outside of GA, like family members, financial institutions, employers, or the justice system, might find out about them having a gambling problem.

Although these potential risks were minimal, I did try to minimize any discomfort or distress experienced by the participants. I was available to participants, at GA meetings, during conferences, and online via email, to respond to any questions or concerns.

I believe that the benefits of this study far outweighed the minimal risks. Although I could not guarantee that each participant would receive a benefit from participating, I believe that the opportunity for participants to bring their treatment issues and problems into the open was validating and a positive step forward. Hopefully, the findings of this study can be used to help other women obtain the treatment they need to recover from this addiction. I also hope that this study will provide increased awareness and understanding of the problems women face in seeking treatment for their gambling problem.

4.0 RESULTS

The first two sections of this chapter present the background and gambling behavior severity data for the 90 women who provided usable questionnaires. The third section reports on the respondents' involvement with formal and informal sources of help, while the fourth section presents the data on mental health and addictive disorders. The next sections are organized to correspond to the study's research questions:

1. What are the individual issues, socio-environmental factors, and programmatic characteristics that create barriers to treatment for women who have a gambling problem?
2. What are the barriers to treatment identified by women actively involved in the gambling self-help group Gamblers Anonymous (GA) compared to those identified who were not actively involved in GA?
3. What are the barriers to treatment identified by women who received formal gambling treatment compared to those who did not receive formal gambling treatment?
4. What are the responses, including the barriers to treatment, identified by women who completed the questionnaire compared to those who used email?

Additionally, this chapter presents the results from the analyses of the eight open-ended research questions. These data provide information about the feelings, thoughts, and opinions held by study participants about their experiences or perceptions of seeking help for a gambling problem.

4.1 BACKGROUND CHARACTERISTICS

The sample consisted of 90 women who self-identified as having a gambling problem. Women were recruited from various sites and two methods were used to collect data. Thirty-three (37%) of the respondents were recruited from GA mini-conferences, 30 (33%) respondents were recruited by referral from key GA members, 17 (19%) women were recruited from the Internet, and 10 (11%) women were recruited at GA meetings. All participants were given the option of completing either the paper and pencil format of the questionnaire and returning it by mail or depositing it in a return box, or completing the questionnaire by email and returning it by email or regular mail. Although the survey was presented in two formats, the majority, 64 (71%) participants, completed the pencil and paper version of the questionnaire; 26 (29%) respondents completed the embedded-email format. Nine respondents who completed the embedded email format were not recruited from the Internet, but were recruited by referral from key GA members. Thirty-seven percent of respondents resided in Ontario, followed by Michigan (33%), and locations outside of Ontario and Michigan (30%).

The demographic data are presented in Table 3. The majority of women were Caucasian (86%) and middle-aged. The women's age ranged from 25 to 80, with a mean age of 47 years ($SD=13.86$); fully 80% were between 41 and 65 years of age. Over half of the sample (56%) was married or living with a partner, 26% were divorced or separated, and 19% were widowed or single. Seventy-seven percent of women were mothers, and 29% of the women who were mothers had children under the age of 18 residing with them.

Only 11% of the sample had less than a high school diploma. Thirty-seven percent completed high school and 52% completed community college or university. Two thirds (67%) were employed full and/or part time, 12% were retired, 9% were unemployed, 9% were homemakers, and 3% were receiving a disability pension. Regarding personal incomes, 60% of the sample had an income of less than \$35,000, 26% earned between \$35,000 - \$59,999 and 12%

earned over \$60,000. Generally, personal incomes were lower than household incomes; less than a third (30%) of women lived in households where the household income was \$35,000 or less, 29% had household incomes ranging from \$35,000 to \$59,999, and 40% had household incomes over \$60,000.

Table 3. Demographic Information and Comparison by Data Collection Method

Demographic	Total N (%)
<u>Age:</u>	<u>N=86</u>
25 – 40	13 (15.1)
41 – 55	50 (58.1)
56 – 65	19 (22.1)
66 – 80	4 (4.7)
Mean (SD)	47.3 (13.9)
<u>Race/Ethnic Identity:</u>	<u>N=86</u>
Caucasian	77 (85.5)
Black/African American	6 (6.7)
Other	7 (7.8)
<u>Marital Status:</u>	<u>N=90</u>
Married/Cohabiting	50 (55.6)
Divorced	16 (17.8)
Single, Never Married	12 (13.3)
Separated	7 (7.8)
Widowed	5 (5.6)
<u>Children</u>	<u>N=90</u>
Yes	69 (76.7)
No	21 (23.3)
<u>Number of Children Residing With Respondent:</u>	<u>N=69</u>
None	49 (71.0)
1	13 (18.8)
2	5 (7.2)
3	1 (1.4)
4	1 (1.4)

Table 3 (continued)

Demographic	Total N (%)
<u>Education:</u>	<u>N=90</u>
Elementary School	10 (11.1)
High School	33 (36.7)
Post Secondary	47 (52.2)
<u>Employment:</u>	<u>N=90</u>
Employed	60 (66.6)
• Full-time	51 (56.7)
• Part-time	6 (6.7)
• Full-time and part-time	3 (3.3)
Unemployed	8 (8.9)
Homemaker	8 (8.9)
Retired	11 (12.2)
Disability	3 (3.3)
<u>Personal Income:</u>	<u>N=88</u>
\$14,999 or less	17 (19.3)
\$15,000 - \$34,999	37 (42.0)
\$35,000 - \$59,999	23 (26.1)
60,000 - \$79,999	8 (9.1)
Over \$80,000	3 (3.4)
<u>Household Income:</u>	<u>N=87</u>
\$14,999 or less	6 (6.9)
\$15,000 - \$34,999	21 (24.1)
\$35,000 - \$59,999	26 (29.9)
60,000 - \$79,999	18 (20.7)
Over \$80,000	16 (18.4)
<u>Province or State of Residence:</u>	<u>N=89</u>
Ontario	33 (37.1)
Michigan	29 (32.6)
Outside Ontario or Michigan	27 (30.3)

4.2 GAMBLING SEVERITY

The two instruments used in this study to measure gambling severity were the Gamblers Anonymous 20 (GA20) Questions and the South Oaks Gambling Screen (SOGS). Ninety-nine percent of the sample, or all but one respondent, scored 7 or more on the GA20, which satisfies the criterion score of 7 needed to be classified as a compulsive gambler. The average score for the GA20 was 17, where the scale's possible range is 0 to 20. The responses endorsed by over 95% of respondents included: 'gambled longer than had planned' (100%); 'felt remorse after gambling' (99%); 'gambling to escape worry or trouble' (97%); 'gambling made home life unhappy' (97%); 'gambled until last dollar was gone' (96%); and 'after a win, strong urge to return and win more' (96%).

Ninety-eight percent of respondents achieved a score of 5 or more on the SOGS. Since the criterion to be considered a probable pathological gambler is a 'yes' response to five or more items, almost the entire sample of women gamblers in this study can be considered to be probable pathological gamblers (PPG). The mean SOGS score was 13 (SD = 3.4), where the scale's possible range is 0 to 20. The responses on the SOGS endorsed by 95% or more of the sample included: 'gambled more than intended' (98%); 'felt guilty about the way you gamble or what happens when you gamble' (98%); and 'had a problem with gambling' (97%). A Pearson correlation showed a moderate but significant positive relationship between the respondents' scores on the SOGS and the GA20 ($r = .40, p < .01$).

Respondents reported having gambled an average of 10 years, ranging from 1 to 40 years. The vast majority (94%) reported having stopped gambling completely at the time of the survey. Respondents reported that they had stopped gambling an average of 20 months (SD=31.52) before participating in this study. Over half (60%) of those who said they had stopped gambling indicated that they were abstinent from gambling for 8 months or less and 80% abstinent less than one year. The positively skewed variable 'months of abstinence' (skewness = 2.271) was

recoded into a dichotomous variable called months of abstinence recode (less than one year vs. at least one year). The five participants who reported that they were not abstinent at the time of the survey were excluded from any analysis involving length of abstinence. No demographic variables were significantly related to the dichotomous length of abstinence variable. The SOGS score for participants who were abstinent for less than one year statistically differed from the SOGS score of those abstinent at least one year or more ($t_{(83)} = 4.06, p < .001$), with SOGS scores being significantly higher for participants with a shorter period of abstinence than for participants with a longer period of abstinence ($M = 13.8$ vs. $M = 10.7$, respectively). No significant differences were found for the GA20 total score with relation to the length of abstinence.

Five (6%) women were still gambling at the time of the survey. Those who indicated that they were still gambling were asked: *Why are you not trying to stop gambling?* Reasons for continuing to gamble included: 1) having only attended one GA meeting; 2) hoping/wanting to win back money lost; 3) having to pay off brother's tuition; 4) trying to stop but will have to win to get back money lost; and 5) retaliating against a domineering husband, where the respondent wrote "don't want husband to have all the power, he abuses it."

Ninety percent responded to the question: *What does gambling do for you?* Over one-third (35.6 %) reported that gambling provided a means of 'escape' from their reality, 'numbing the pain' associated with life's problems, masking feelings of inadequacy, or covering up their feelings of loneliness and fear. For example, several respondents wrote:

It gave me time to myself...time free from the demands of being a mom, nurse, wife, chauffeur, cook, cleaner, shoulder to cry on, friend, etc. While playing the machines, I didn't have to think about ANYONE at all or what they needed from me...it also gave me peace from my worries. While playing the machines, I didn't stress over the unpaid bills or the upcoming ones and I sure didn't worry about what kind of parent I was for wanting to escape from my husband and children's demands. While playing the machines, NO ONE asked anything of me as they did in my work and at home. I was most often left alone in the midst of a crowded casino or club. Finally, while playing the machines, I had inner silence - no more beating up on myself for having over spent all those other days.

I was responsible for losing all my assets. I lost my house, car, most of my personal possessions. I was twice admitted to a psychiatric ward for depression as a direct result of my gambling. I went to prison for three years as a result of a staged armed robbery where I had a plastic gun and wanted the cops to shoot me. I made several other suicide attempts. I gambled because I could zone out of the real world and it provided me with a great escape from myself.

Although ‘gambling as an escape’ was a dominant theme among the women, nine respondents characterized gambling as providing not only an escape from their worries, but also a source of excitement or a main form of entertainment. One woman wrote, “Gambling provided a rush of excitement, a means of escape from negative feelings and fooled me into thinking that a big win would solve all my problems.” Another woman wrote:

Gambling initially was a fun and social activity, as it progressed I would go and gamble alone, further isolating myself. I felt that gambling numbed me out so I would not think about my problems. It allowed me to escape the reality of low self-esteem and bent on self-destruction, only realizing it perpetuated the low self-esteem and self-destructive urges.

The sentiment ‘gambling did nothing positive for me’ was expressed by 19% of the respondents. Retrospectively, they described feeling worthless, depressed, selfish, and careless as a result of their gambling problems, and reported “gambling had taken away the happiness” in their life. One woman said:

Gambling didn’t do anything for me. It created distrust from spouse, became a liar, cheat, thief, felt guilty all the time, money arguments, low self esteem, low self-confidence, an escape artist from all life’s responsibilities, created greed, became a manipulator, sarcastic, and basically humorless, had the “world is out to get me” attitude or “I’m owed something in this life.” Towards the end of my gambling career it’s not that I wanted to commit suicide, I wanted it all to disappear around me like I never existed to begin with.

Another theme identified by 17% of the respondents was ‘gambling ruined/destroyed my life.’ These women wrote about the losses they suffered in terms of family, friends, and careers; they also reported committing illegal acts to gamble. Several of these responses were:

Ignored ethics and morals. Made me obsessed with its pursuit and forget all else. Destroyed my life: Health (physically), sanity (mentally), promiscuity (emotionally), spiritually. Ruined longtime relationship.

Gambling has ruined my life! I've attempted suicide, lost respect of family and friends. It has overall been the worst thing I've ever done. I have survived many hardships through my life, i.e. bad childhood and family life, a very abusive marriage (verbal, sexual and physical), drugs, alcohol, being raped at gun point, raising children on my own, but gambling took away what ever will power I thought I had and left me with no desire to live like that anymore. Gambling took almost everything from me including my life.

Three respondents wrote about enjoying the 'action' of gambling. The term 'action' is used in reference to the high or euphoric feeling some gamblers describe experiencing when gambling. Typically, the term 'action gambler' is associated with male gamblers who are perceived to fit the stereotype of the big spender (Lesieur & Blume, 1991, p. 185).

Sixty-one percent responded to the question: *What problems has gambling caused you in your life?* The women reported that, in varying degrees, gambling affected multiple aspects of their life and of the lives of those around them. Women reported that the consequences associated with gambling reached far beyond them, often destroying their finances, relationships with family and friends, and their careers and employment. For example, one woman wrote:

Self-hatred...lowered self-esteem...lack of trust in myself and my ability to control my actions...doubts my sanity...loss of direction and purpose...major sleep deprivation and all that ensues from that...mental, physical and emotional breakdown...an inability to accept help/support from family and friends...marriage breakdown...major guilt over how my children have been affected...mood swings.

The following responses capture the destructive and ubiquitous effects of a gambling problem:

Neglect of my children, myself, my spouse, my home, my job, etc... I seemed to have blinders on and was oblivious to just how neglectful I had become. Financial debts and juggling of finances to cover debts, as well as loans, borrowing, and cashing in bonds and savings. I had felt so isolated and alone.

Loss of job put relationship with husband, children and extended family at risk. Created debt that we couldn't afford. Led to loss of values, feelings, depression and anxiety.

Financial disaster...debt...debt...debt. And I was not the person I used to be before I got into the compulsion...the lying, cheating...trying to keep everything secret.

I have destroyed my credit and I live in fear for what they will do to me. My 26-year marriage is close to being destroyed. I live every day in fear, self-disgust, guilt, and remorse.

4.3 FORMAL AND INFORMAL HELP

Formal help included residential treatment, outpatient treatment, psychiatric/medical treatment, private counseling or therapy, crisis service, telephone crisis line, and other formal services. Women were asked if they ‘wanted,’ ‘tried to obtain,’ or ‘received’ these various forms of help for their gambling problem. Prochaska and DiClemente’s (1986) transtheoretical or stages of change model, widely used in the treatment of addictions, explains the various stages individuals experience when making changes. Prochaska and DiClemente (1986) conceptualized change along a continuum that includes: precontemplation, contemplation, action, and maintenance. Underlying the precontemplation stage is denial that a problem exists; in the contemplation stage, the pros and cons for altering the behavior are considered. In the action stage, efforts to change are made, and in the maintenance stage, the focus is on sustaining improvement. The theory proposes that behavior change occurs according to these stages but that individuals can also regress to earlier stages. In this study for example, women may have contemplated wanting help for their gambling problem and yet never tried or received help. Or they may have tried to get help, making an initial phone call perhaps, but not received help either because they did not follow through or because the service system was not responsive. Or they may have decided they wanted to change, sought help, and obtained treatment. The formal types of help are presented in Table 4.

Eighty-one percent of women reported receiving formal types of help; 80% either wanted or tried to receive formal help. These data show that similar numbers of women wanted, tried to

receive, and did receive formal types of help. Among those receiving formal help, 80% received treatment from private counseling or therapy, 43% received out-patient treatment, 41% received crisis help, 38% received psychiatric or medical help, 27% received residential or in-patient treatment, and 10% received other forms of help, including employee assistance and financial counseling.

Treatment seekers compared to non-treatment seekers were younger ($M=49$ vs. $M=51$), more likely to be Caucasian (89% vs. 82%), married or cohabitating (58% vs. 47%), and mothers (78% vs. 71%). As well, more women who received formal help completed post-secondary education (27% vs. 18%) and had household incomes over \$60,000 (41% vs. 29%). Of the 33

Table 4. Formal and Informal Help - Wanted, Tried, and Received Assistance

Treatment Option	Wanted Treatment	Tried To Get Treatment	Received Treatment
Formal Help	n (%)	n (%)	n (%)
Residential treatment	19 (26.4)	17 (23.6)	20 (27.4)
Out-patient counseling	40 (55.6)	34 (47.2)	31 (42.5)
Medical treatment e.g. primary care physician, psychiatrist	35 (48.6)	29 (40.3)	28 (38.4)
Private counseling/therapy	59 (81.9)	56 (77.8)	58 (79.5)
Crisis 'hot-line'/telephone counseling	33 (45.8)	32 (44.4)	30 (41.1)
Other formal help e.g. credit counseling, union, employee assistance	7 (9.7)	7 (9.7)	7 (9.6)
Any formal help	72 (80.0)	72 (80.0)	73 (81.1)
Informal Help	n (%)	n (%)	n (%)
Gamblers Anonymous	80 (92.0)	81 (92.0)	81 (91.0)
Internet self-help e.g. CGHub	39 (44.8)	36 (40.9)	34 (38.2)
Support from family and friends	70 (80.5)	63 (71.6)	60 (67.4)
Other self-help e.g. Self-help books, other and women's only support group etc.	15 (17.2)	15 (17.1)	14 (15.7)
Any informal help	87 (96.7)	88 (97.8)	89 (98.9)

women living in Ontario, 91% received formal treatment. However, none of the demographic characteristics were statistically related to whether or not formal treatment was received.

Further analysis explored if those who did and did not receive formal treatment differed in terms of their total gambling severity scores. Respondents who received formal help had statistically higher total SOGS score than those who didn't receive formal treatment ($M=13.0$ vs. $M=10.9$, $t_{(88)} = 2.1$, $p < .05$). The means for total GA20 scores did not statistically differ in relation to receipt of formal treatment ($M=17.4$ vs. $M=16.8$, $t_{(88)} = .67$, $p = .5$).

Women were asked if *formal treatment services had helped with their gambling problem?* Among respondents who reported having received formal treatment, more than half (59%) indicated that formal services had helped with their gambling problem; 32% reported that formal services had not helped. Four percent reported that formal services had been both helpful and not helpful.

Women described being helped by counselors, therapists, psychologists, and psychiatrists working in private practice as well as in outpatient and residential treatment programs. Through the course of treatment, women described being educated about their gambling addiction and were taught to identify, understand, and learn new ways to cope with their feelings and emotions. Some reported that counseling helped them to confront their issues, take responsibility for their actions, and stop blaming others for their life's problems. Others described their initial reluctance in accepting the 'hard-lined' abstinence model (compared to harm-reduction) used by counselors. Several women reported the following about their experiences with formal help:

Having a therapist/counselor has helped me understand what the first line of GA's Step One says, "we have an emotional illness, progressive in nature." It was very important for me to learn about how my personal history played a part in my mind to escape and my inability to deal with life on life's terms. Learning to identify and deal with feelings has been crucial to my recovery.

My counselor helped me get through dealings with police and courts.
YES, all of the above has helped immensely. I have stopped blaming the people around me.

I saw a therapist trained in compulsive gambling. She took a hard-line approach and told me that until I stopped gambling there was nothing that I could say that she could listen to (addictive thinking). It was the best thing she could have done. I stopped gambling, went to GA and continued therapy.

I was fortunate to get into a 28-day program for addictions. It was there that I was introduced to a 12-step program. It was with the help of my counselor and this program that I started to face real issues in my life that I had been escaping from and avoiding all my life. Both the program and counselor allowed me to honestly look at myself without feeling like a failure.

The Program - taught me to change my life style and to deal with the problems causing the pain therefore eliminating the need for escape. Balancing the needs in my life and working on character defects.

Among those who said formal help had not been helpful, one woman reported her anger with being treated like an alcoholic rather than a gambler while in treatment. Another woman reported being treated for the symptoms and not the problem. Yet another commented that “counselors, psychiatrists and doctors lacked the understanding of gambling problems or the rush gamblers experience.”

Table 4 also identifies the informal help utilized by respondents. Ninety-seven percent reported wanting informal help; 98% reported having tried to receive help, and all but one respondent (99%) reported having received informal help for their gambling problem. More respondents reported having received informal help than having wanted such help. Most (91%) reported having received help from Gamblers Anonymous. Internet gambling self-help, such as CGHub, was accessed by 38% of informal help seekers. A majority (67%) of respondents reported receiving support from family and friends; however, it is interesting to note that fully 81% reported wanting help from family and friends and 72% tried to get help from family and friends. Fourteen percent reported using other forms of self-help including reading self-help

books, attending other self-help meetings or women's support groups, having contact with their sponsor, attending GA conferences, and listening to motivational speakers.

Respondents were asked to explain if *informal services helped with their gambling problem*? Almost the entire sample (97%) reported that informal help in one form or another had assisted them with their gambling problem. Overwhelmingly, women extolled the virtues of GA, identifying feeling loved, friendship, understanding and acceptance as key elements of their affiliation with the organization. Some women noted that GA had 'saved their life' or had been a source of inspiration or redemption. Women reported that the 12 steps had helped them 'work through' gambling and life issues. GA provided a sense of belonging to a community; a network of support that provided them with a place where they did not feel alone or isolated. The support received from GA was described in the following ways:

From my first meeting 12 years ago, I have not gambled. I have a better way of life today. My life has turned completely around today. I'm involved in GA.

More than a support system – it's a very close group of friends who share the same illness as I do. Some friendships are the closest that I've ever shared in my life. We laugh, we cry, we celebrate and support one another in times of sadness and joy.

I feel like I belong to something. It gives me somewhere to go and I don't feel so lonely and isolated.

Gamblers Anonymous has helped me tremendously even though I gambled only 2 days ago. I went under great health stress – possibly cancer and used it for few hours of escape. But, I returned to GA meeting the next night. I find GA group therapy very rewarding and helpful. Everyone is not judgmental of accusing, questioning – the key word here is understanding and great support. After meetings is still on going therapy – I have nothing but praise for this program and hope that I make a 1 year pin at sometime. I continue to take ONE DAY at a TIME. I will make it.

Helps me to understand that I am not alone in this addiction and the fellowship holds us together.

One woman wrote about the benefits of her involvement with both GA and on-line support in the following way:

For me, GA has been the best help. I relate to the stories of others because for the most part they are similar to my experience gambling. Can relate quite well to feelings on that mental roller coaster ride. In the beginning of my Internet use with the CGHUB I considered the hub as a supplementary tool to the GA program and my recovery. Now the HUB has become much more as I have made a few close friends that make up part of my support group. With exception of my former spouse, who was not very supportive from the beginning, my friends and family have been very supportive. Through this program I have a better relationship with my brother; the relationship with my parents has grown stronger. The few close friends that I have been very supportive of my abstinence and recovery and have a basic understanding as to why I choose to do this program. GA FOR ME IS A LIFE GIVER, it has given me a chance to continue on with my life as 'normally' as possible without placing a bet.

Women reported relying on the Internet for support because of its accessibility or, for others, the lack of availability of GA meetings in their area. One woman wrote:

CGHUB has been an invaluable source of support and inspiration. My recovery program has been 95% online with the CGHub and the connections I have made to help me help myself. The 12-Step recovery program of GA has literally changed my life. It is becoming a way of life for me, one day at a time.

Four percent reported that informal services had not been helpful. These respondents complained about the lack of availability of GA meetings or the perceived lack of understanding from other GA members about their experiences.

Respondents were asked *who recommended they get help for their gambling problem?* The majority (70%) reported that they referred themselves. Although 65% said they received support from their spouse or partner in getting help, less than a third (29%) reported that their spouse/partner recommended they get help. Twenty three percent said that a family member other than someone in their immediate family recommended they get help. Others recommending that respondents seek help included: psychologist (17%); friend (14%); child

(13%); doctor (8%), employer (6%), social worker (2%), social service agency (1%), lawyer (1%), and, the court system (1%), as a condition of probation.

Respondents were asked *who in your life, such as a family member or friend, has (or had) a gambling problem?* Fully, 74% identified one or more of the people in their life as having a gambling problem. The most common response was a friend (34%). However, family members also were frequently mentioned: sibling (31%), father (30%), other family member (25%), mother (23%), grandparent (14%), spouse or partner (10%), and child (8%)

4.4 COMORBIDITY OF MENTAL HEALTH AND OTHER ADDICTIONS

The majority (84% or 76 respondents) reported feeling seriously depressed. Of those reporting feeling seriously depressed, 74% (56) related their depression to gambling, 13% (10) to alcohol abuse, 3% (2) to drug abuse, and the remaining 8 respondents did not identify what they related their depression to. Nineteen percent reported that their gambling problem surfaced during the course of treatment for other problems.

Respondents' overwhelming feelings of hopelessness and despair were reflected in the fact that 33% (30) reported having attempted suicide. Of those reporting having attempted suicide, 57% (17) related their suicide attempt to gambling, 10% (3) related it to alcohol abuse, and 3% (1) said their suicide attempt was related to drug abuse. The remaining 30% did not identify the reasons for attempting suicide.

No statistical differences were found between those who had attempted suicide compared to those who had not attempted suicide on either SOGS total scores ($M = 12.97$ vs. $M = 12.4$ ($t_{(88)} = -.74$, $p = .46$) or GA total scores ($M = 17.5$ vs. $M = 17.2$ ($t_{(88)} = -.48$, $p = .63$). No statistical differences were found when those who reported that their suicide attempt was related to their

gambling problem were compared to those who did not relate their suicide attempt to their gambling problem in relation to SOGS total scores ($M=12.7$ vs. $M=12.7$, $t_{(53)} = .01$, $p = .99$). However, respondents who reported that their suicide attempt was related to their gambling problem had statistically higher total GA20 scores than those who did not relate their suicide attempt to their gambling problem ($M=18.8$ vs. $M=16.5$, $t_{(48)} = -3.4$, $p < .01$).

Almost half of the sample (47%) reported having received treatment in adulthood for a mental health or addictive disorder other than gambling. These disorders are presented in Table 5. Sixty percent reported having been treated for depression, while 40% were treated for various other mental health disorders including anxiety, mood, personality, eating, and schizophrenia. Nineteen percent reported receiving treatment for substance abuse, most often for alcohol abuse. Twenty-one percent identified having received treatment for two or more mental health or mental health and substance abuse disorders, which included: depression and anxiety; alcohol

Table 5. Disorders Treated in Adulthood Other Than Gambling

Disorder (N=42)	n (%)
<u>Anxiety Disorder:</u>	
Generalized Anxiety	4 (10)
Panic	2 (5)
Posttraumatic Stress (PTSD)	1 (2)
<u>Mood Disorder:</u>	
Depression	25 (60)
Bipolar	3 (7)
Dysthymia	1 (2)
<u>Personality Disorder:</u>	
Dependent Personality	1 (2)
<u>Psychotic Disorder:</u>	
Schizophrenia	3 (7)
<u>Addiction Disorder:</u>	
Alcohol	7 (17)
Drug	1 (2)
<u>Eating Disorder:</u>	
Bulimia/ Binge-Eating	3 (7)

abuse and depression; depression and post-traumatic stress disorder; depression, schizophrenia and alcohol abuse; alcohol abuse and bulimia; depression and schizophrenia; depression, anxiety, and alcohol abuse; and, personality disorder and eating disorder.

4.5 BARRIERS TO TREATMENT

The primary goal of this study was to identify the specific barriers inhibiting women gamblers from getting help. Barriers to treatment were identified within 3 broad domains: individual, socio-environmental and programmatic issues. The overall mean for the women in this study was 18.5 (SD=13.5); 6 respondents reported 0 barriers. Correlations among the three barriers subscales were positive and statistically significant: the individual barriers subscale was moderately correlated with the socio-environmental subscale ($r = .60, p < .01$) and the programmatic barriers subscale ($r = .52, p < .01$) and the socio-environmental subscale was moderately correlated with the programmatic subscale ($r = .61, p < .01$).

4.5.1 Individual Barriers

The individual barrier items are presented in Table 6. The individual barrier items identified most frequently as ‘a lot’ by respondents included: (1) Feeling ashamed to admit that gambling is a problem (37%); (2) Feeling lonely without gambling in my life (37%); and (3) Afraid of what people will think of me if I get help for my gambling problem (28%). Moreover, half or more of the women identified the following items from the individual issues subscale as presenting at least “some degree or more” of a barrier to their getting treatment: (1) Feeling ashamed about my gambling problem (69%); (2) The loneliness felt without gambling in my life

Table 6. Individual Barriers to Treatment Identified by Women Gamblers (N=90)

Treatment Barriers	Not At All n (%)	A Little n (%)	Somewhat n (%)	A Lot n (%)	Rank Order	
					11 Items	32 Items
Individual Issues						
Feeling ashamed to admit that gambling is a problem	28 (31)	7 (8)	22 (24)	33 (37)	1	2
Not able to remain abstinent	51 (57)	10 (11)	13 (14)	16 (18)	6	7
Not able to afford the costs associated with getting help	71 (78)	4 (4)	7 (8)	8 (9)	9	14
No health insurance to cover the cost of getting help	77 (86)	2 (2)	3 (3)	8 (9)	10	19.5
Not trusting doctors, clinics or hospitals can help me	68 (76)	7 (8)	9 (10)	6 (7)	8	13
Feeling that gambling is not a problem for me	45 (50)	16 (18)	10 (11)	19 (21)	5	6
Not letting health problems interrupt my life	71 (79)	11 (12)	6 (7)	2 (2)	11	21
Having responsibilities at home as a mother, wife, or partner	61 (68)	11 (12)	13 (14)	5 (6)	7	10
Raised to believe that I should take care of my own problems	37 (41)	13 (14)	21 (23)	19 (21)	4	5
Feeling lonely without gambling in my life	29 (32)	11 (12)	21 (23)	29 (32)	2	3
Being afraid of what people will think of me if I get help for my gambling problem	39 (43)	10 (11)	16 (18)	25 (28)	3	4
Individual Issues Subscale Score (M/SD)				M=9.9, SD=6.8		
N (%) reporting at least one individual barrier				81 (90%)		

(68%); (3) Raised to believe I should take care of my own problems (59%); (4) Feeling afraid of what others will think if I go into treatment for a gambling problem (57%); and, (5) Denial or believing that gambling is not a problem for me (50%). Conversely, respondents identified the following items least often as barriers to treatment: (1) No health insurance to cover the cost of getting help (14%); (2) Not able to afford the costs associated with getting help (21%); (3) Not letting health problems interrupt my life (21%); and (4) Not trusting that doctors, clinics or hospitals can help (24%).

The item ‘feeling ashamed to admit that gambling is a problem’ was ranked first among the 11 individual barrier items and second among the 32 items in the full scale. The individual barrier item ‘feeling lonely without gambling in my life’ was ranked second within the individual barrier subscale and third in the overall scale. The individual barrier item ‘not letting health problems interrupt my life’ was ranked last among the individual barrier items and 21st among the 32 total items.

Ninety percent of the respondents identified one or more individual barrier items. Race was statistically related to reports of experiencing one or more individual barriers: 94% of Caucasian respondents reported one or more individual barriers compared to 69% of the non-Caucasian respondents ($X^2=7.3$, $p<.01$). Other variables including level of education, age, marital status, employment status, household income, province or state, total SOGS score, total GA20 score, ever depressed, depression related to gambling, attempted suicide, and suicide attempt related to gambling, were not associated with whether or not the respondent reported individual barriers to treatment.

The mean of the individual barriers subscale was 9.9, with a range of 0 to 29. The subscale score differed statistically in relation to race with Caucasian respondents reporting, on average, a higher individual barriers subscale score than non-Caucasian respondents ($M=10.6$ vs. $M=5.8$, $t_{(88)}=2.4$, $p. < .05$). In addition, the subscale score differed statistically in relation to feeling depressed, and respondents who reported that they had suffered from depression had a higher mean individual subscale score than those who had not been depressed ($M=11.1$ vs. $M=3.8$, $t_{(88)}=-3.97$, $p. < .01$). The mean individual subscale score was not statistically related to level of education, age, marital status, employment status, household income, province or state, the SOGS total score, the GA20 total score, depression related to gambling, attempted suicide, and suicide attempt related to gambling.

Thirty percent of the women responded to the open-ended question: *What issues in your personal life affected you getting help for your gambling problems?* Although this question specifically asked about personal issues and followed the individual issues sub-section of the barriers to treatment scale, the responses fell into three main categories: individual, socio-environmental and programmatic issues. The majority of those who responded (82%) identified individual or personal issues, 7% identified socio-environmental issues, and 11% identified programmatic issues.

Feelings of shame, guilt, and fear were expressed by many of these respondents. Women reported being fearful of consequences, of losing their children, family, friends, or jobs. Women reported they ‘loved’ gambling and recognized they either lacked will power or were in denial about how serious and problematic their gambling had become. Comments included:

I knew I was hooked and wanted to stop, yet, had no will power to control my gambling.

The shame, the honesty required, the perfectionist in me prevents me from admitting I have a problem.

Fear of the unknown and fear of what I would learn and feel about myself.

My negative counselling experience with the social worker. A huge amount of fear that my then husband would use my gambling past to take my children from me and I would not be able to prove that I had quit.

Nothing really except for my own unwillingness to accept the fact that gambling was/is an addiction and that I could not stop on my own. I suppose that was because I really didn't understand what a gambling addiction really was. Because I always felt like I had failed in so many things and fallen short on my parents' expectation of me, I guess I didn't want them to think that I had failed in something else. I wanted to stop gambling on my own perhaps to show them that I could succeed at that. How stupid that sounds now when I say that. I have nothing to prove to anyone. It's funny but once I accepted my own problems and stopped worrying about what others thought of me, my life started to change. I started to change. You might say I started to grow up.

4.5.2 Socio-environmental Barriers

Socio-environmental factors included items such as: not being able to take time off work; fear that children will be taken away; being protected by the negative results of gambling problems; and no encouragement from family and friends to get help. The socio-environmental barrier items are presented in Table 7. In contrast to the individual-level barriers where 5 items were endorsed by at least half of the women, only one socio-environmental barrier item was identified by half or more of the women. This item was 'gambling to deal with stress' (73%), with 41% characterizing this as 'a lot' of a barrier to treatment. Conversely, respondents least often identified issues involving children and work as treatment barriers. These items included:

‘having fear children will be taken away’ (7%); ‘having no one to care for children’ (10%); and ‘not able to take time off work’ (14%).

Not surprisingly given the above, the item ‘needing to gamble to deal with the stress of daily life’ was ranked first among the socio-environmental barrier items; it also ranked first among the 32 total items. The item ‘gamble to deal with stress’ differed statistically in relation to the variable ‘depression related to gambling’; 86% of respondents reported that their depression was related to their gambling, compared to 56% who attributed their depression to some other source ($X^2=8.5$, $p<.01$).

The socio-environmental barrier item ‘protected from the negative results of gambling’ was ranked second within the socio-environmental barrier subscale and ninth among all the barriers items. The socio-environmental barrier item ‘fear I won’t be accepted by my friends’ was ranked last among the socio-environmental barrier subscale and 15th overall.

Eighty-two percent (84) of respondents reported one or more socio-environmental barrier items. The SOGS total score was statistically related to whether respondents experienced socio-environmental barriers, with those having higher SOGS total scores more likely to report one or more socio-environmental barriers than those with lower SOGS scores ($M=13.2$ vs. $M=9.5$, $t_{(88)}=-4.1$, $p<.001$). Being depressed was statistically related to experiencing socio-environmental barriers, where 87% of those reporting they were depressed, compared to 57% of those who were not depressed, reported one or more socio-environmental barriers ($X^2 = 7.1$, $p<.01$).

Similarly, the variable ‘depression related to gambling’ was statistically related to those experiencing socio-environmental barriers, where 91% who reported that their depression was related to gambling compared to 72% who did not, reported one or more socio-environmental barriers ($X^2=4.9$, $p<.05$). Other variables including race, level of education, age, marital status, employment status, household income, province or state, total GA20 score, and suicide attempt,

Table 7. Socio-Environmental Barriers to Treatment Identified by Women Gamblers (N=90)

Treatment Barriers	Not At All n (%)	A Little n (%)	Somewhat n (%)	A Lot n (%)	Rank	
Socio-environmental Factors					10 Items	32 Items
No encouragement from family/ friends to get help	63 (70)	10 (11)	11 (12)	6 (7)	3	11
Fear I won't be accepted by my friends	68 (76)	9 (10)	9 (10)	4 (4)	10	15
No one to care for my children	81 (90)	6 (7)	1 (1)	2 (2)	8	30
No meetings/programs in my area	70 (78)	5 (6)	6 (7)	9 (10)	4	12
Anger from husband/partner/ boyfriend for being abstinent	72 (80)	5 (6)	7 (8)	6 (7)	5	16
Afraid children could be taken away	84 (93)	2(2)	2 (2)	2 (2)	9	31
Not able to take time off work	77 (86)	7 (8)	3 (3)	3 (3)	7	24
Living in a community where it is expected that I gamble	73 (81)	9 (10)	5 (6)	3 (3)	6	22
Protected from the negative results of gambling	59 (66)	13 (14)	11 (12)	2 (8)	2	9
Needing to gamble to deal with the stress of daily life	24 (27)	13 (14)	16 (18)	37 (41)	1	1
Socio-environmental Factors Subscale Score (M/SD)					M=5.1, SD=4.5	
N (%) reporting at least one socio-environmental barrier					84 (82%)	

and suicide attempt related to gambling were not associated with whether or not the respondent reported any socio-environmental barriers to treatment.

The mean of the socio-environmental barrier subscale was 5.1, with a range of 0 to 20. Respondents who reported they were depressed had a statistically significant higher mean socio-environmental barrier subscale score than those who reported that they were not depressed ($M=5.5$ vs. $M=2.6$, $t_{(88)} = -2.3$, $p < .05$). The mean socio-environmental barrier subscale score also differed statistically in relation to the variable ever attempting suicide; respondents who had attempted suicide had a higher mean socio-environmental barrier subscale score than respondents who reported that they had not attempted suicide ($M=6.5$ vs. $M=4.4$, $t_{(88)} = -2.1$, $p < .05$). The mean socio-environmental barrier subscale score was not statistically related to other variables including race, level of education, age, marital status, employment status, household income, total SOGS score, total GA20 score, province or state, depression due to gambling and suicide related to gambling.

Twenty-seven percent (25) responded to the open-ended question that followed the socio-environmental barriers sub-section: *What other issues in your life have kept you from getting help for your gambling problem?* Comments fell into four broad themes including denial that a problem exists, experiencing boredom and loneliness in their lives, unsupportive family and the excitement that gambling brings them. These themes are reflected in the following comments:

What to do with spare or free time especially weekends when alone. Holidays when others are with family, my family away on holidays -again- boredom, loneliness - escape from illness or worry - hoping to recoup finances.

I am getting help now, but before, even though I had a problem, I didn't feel like I wanted to stop. I loved going to the casino, and it was my favorite activity besides watching my son's sporting events. When I went by myself, I enjoyed getting away from home, husband, family, housework, etc. I didn't feel I wanted to give that up, until I hit rock bottom and knew I had to give it up or I was going to end up in further financial destruction.

I enjoy it. It's my timeout away from everyone. Because I hate T.V. and there's nothing else to do. I hate Hollywood so I don't go to the movies.

Nothing – I just love the action. Lights – noise – people (24/7).

I did not want to stop what gave me shelter from everything I feared and hated in my life.

My ex-spouse was very unsupportive on my receiving the help that I deserve to overcome my gambling problem. He used to tell me that if I really wanted to stop I could and it starts in here, tapping himself on the chest over his heart and tapping his head. And I believe what he said, that basically I didn't need any support to stop. Finally when I did get into a support group, GA, I was able to stop. I cannot say that I will never go back to gambling. What I can say is I have stopped ONE DAY AT A TIME. I can handle one day better than I can handle an eternity.

4.5.3 Programmatic Barriers

Programmatic barriers refer to characteristics of treatment programs and services that limit help seeking. These barrier items are presented in Table 8 and include items such as: not knowing what help is available; waiting for an opening in a treatment program; the distance of a treatment program; no treatment follow-up; lack of knowledge of program staff; and, not having transportation to a treatment program. There were no programmatic characteristics that were identified as a barrier by half or more of the women. However, 47% endorsed 'not knowing what help is available' as a barrier to treatment and 16% identified this item as being "a lot" of a barrier.

Conversely, the programmatic barriers that were reported the least (i.e., seen as 'not at all' of a barrier) included: (1) Formal treatment programs that have men as well as women (91%); (2) No treatment follow-up (90%); (3) Having to wait for an opening in a formal treatment program (90%); (4) The behavior of staff in formal treatment programs (89%); and (5) No available transportation to treatment program (89%).

Table 8. Programmatic Barriers to Treatment Identified by Women Gamblers (N=90)

Treatment Barriers	Not At All n (%)	A Little N (%)	Somewhat n (%)	A Lot n (%)	Rank	
					11 Items	32 Items
Programmatic Characteristics						
Not knowing what help is available in my area	48 (53)	15 (17)	13 (14)	14 (16)	1	8
Having to wait for an opening in a formal treatment program	81 (90)	1 (1)	5 (6)	3 (3)	7	26
Behavior of staff in formal treatment program	80 (89)	4 (4)	3 (3)	3 (3)	8.5	27.5
Talk about problems with a male counselor	78 (87)	5 (6)	4 (4)	3 (3)	5.5	24
Far distance of formal treatment program from my home	71 (79)	8 (9)	7 (8)	4 (4)	3	18
No available transportation to treatment program	80 (89)	4 (4)	3 (3)	3 (3)	8.5	27.5
Talking in a group where men are present	78 (87)	4 (4)	6 (7)	2 (2)	5.5	24
Formal treatment programs that have men as well as women	82 (91)	2 (2)	4 (4)	2 (2)	10	29
No treatment follow-up	81 (90)	7 (8)	2 (2)	0 (0)	11	32
No confidence in formal treatment program to teach me what I need to know	71 (79)	8 (9)	9 (10)	2 (2)	4	19.5
Lack of knowledge about gambling problem from staff	69 (77)	9 (10)	10 (11)	2 (2)	2	17
Programmatic Characteristics Subscale Score (M/SD)					M=3.5, SD=4.6	
N (%) reporting at least one programmatic barrier					61 (68%)	

The item ‘not knowing what help is available in my area’ was ranked first among the programmatic barrier items and 8th overall among the 32 items. The programmatic barrier item ‘lack of knowledge about gambling problem from staff’ was ranked second within the programmatic barrier subscale and 17th overall. The programmatic barrier ‘no treatment follow-up’ was ranked last among the programmatic barrier items and last overall among the 32 items.

Sixty-eight percent (61) of respondents endorsed one or more programmatic barriers. The variables race, level of education, age, marital status, employment status, household income, province or state, total SOGS score, total GA20 score, ever depressed, depression related to gambling, attempted suicide, and suicide attempt related to gambling were not associated with whether or not the respondents reported one or more programmatic barriers to treatment.

The mean of the programmatic barrier subscale was 3.5, with a range of 0 to 20. The programmatic subscale score differed statistically in relation to the province or state where respondents resided; respondents from Other provinces or states had a higher mean programmatic barrier subscale score ($M=4.6$, $SD=4.4$) than respondents from Ontario ($M=4.2$, $SD=5.5$) and Michigan ($M=1.7$, $SD=2.9$; $F(2, 86) = 3.5$, $p < .05$). The mean programmatic subscale score also differed statistically in relation to ever attempting suicide; respondents who had attempted suicide had higher mean programmatic barrier subscale scores than respondents who reported that they had not attempted suicide ($M=5.0$ vs. $M=2.7$, $t_{(88)} = -2.2$, $p < .05$). The programmatic barrier subscale score was not statistically related to race, level of education, age, marital status, employment status, household income, province or state, total SOGS score, total GA20 score, ever being depressed, depression related to gambling, and suicide attempt related to gambling.

4.6 COMPARISON OF TREATMENT BARRIERS

4.6.1 Treatment Barriers Among Respondents Involved with GA and Not Involved with GA

An aim of this study was to compare the treatment barriers identified by women involved and not involved with GA. Table 9 identifies the treatment barriers reported by those who received help from GA and those who reported they did not. Overall, 93% reported having ‘received’ help from GA. No statistical differences were found when those who received help from GA were compared to those who did not in relation to the mean barriers subscale scores. Respondents who had not received help from GA had a higher mean socio-environmental barrier subscale score (M=5.5 vs. M=5.0); slightly higher mean programmatic barriers subscale score (M=3.5 vs. M=3.4); and a slightly lower mean individual barriers subscale score (M=9.5 vs. M=9.8) when compared to those who had GA involvement.

The most frequently endorsed treatment barriers among at least half of the respondents who had received help from GA included: (1) Need to gamble to deal with the stress of my daily life (73%); (2) Feeling ashamed to admit I have a gambling problem (67%); (3) Feeling lonely without gambling in my life (67%); (4) Raised to believe I should take care of my own problems (58%); and (5) Afraid of what people will think of me if I get help for my gambling (56%).

In comparison, the treatment barriers identified the most among the 6 women who did not receive help from GA included: (1) Feeling ashamed to admit I have a gambling problem (83%); (2) Need to gamble to deal with the stress of daily life (67%); (3) Feeling lonely without gambling in my life (67%); (4) Not knowing what help is available in my area (67%); (5) Raised to believe I should take care of my own problems (50%); (6) Afraid of what people will think of me if I get help for my gambling (50%); (7) feeling that gambling is not a problem for me (50%); (8) Not able to remain abstinent (50%); and (9) have responsibilities at home as a wife, mother or partner (50%).

Table 9. Barriers to Treatment Identified by Respondents Who Received and Did Not Receive Help from GA

Treatment Barriers	Help from GA (n=81)		No Help from GA (n=6)		Statistic
	M	(SD)	M	(SD)	
Total Barriers Score	21.4	(16.4)	22.2	(15.9)	NS
Individual Issues Subscale Score	9.8	(6.9)	9.5	(5.9)	NS
Individual Issues:	n	(%)	n	(%)	
Feeling ashamed to admit that gambling is a problem	54	(66.7)	5	(83.3)	NS
Not able to remain abstinent	34	(42.0)	3	(50.0)	NS
Not able to afford the costs associated with getting help	18	(22.2)	0	(0)	NS
No health insurance to cover the cost of getting help	12	(14.8)	0	(0)	NS
Not trusting that doctors, clinics or hospitals can help me	19	(23.5)	1	(16.7)	NS
Feeling that gambling is not a problem for me	40	(49.4)	3	(50.0)	NS
Not letting health problems interrupt my life	17	(21.0)	2	(33.3)	NS
Having responsibilities at home as a mother, wife, or partner	25	(30.9)	3	(50.0)	NS
Raised to believe that I should take care of my own problems	47	(58.0)	3	(50.0)	NS
Feeling lonely without gambling in my life	54	(66.7)	4	(66.7)	NS
Being afraid of what people will think of me if I get help for my gambling problem	45	(55.6)	3	(50.0)	NS

Note: Except where noted X²statistic was used and was non-significant (NS).

Table 9. (continued)

Treatment Barriers	Help from GA (n=81)		No Help from GA (n=6)		Statistic
	M	(SD)	M	(SD)	
Socio-environmental Factors Subscale Score	5.0	(4.5)	5.5	(4.5)	NS
Socio-environmental Factors:	n	(%)	n	(%)	
No encouragement from family/ friends to get help	24	(29.6)	1	(16.7)	NS
Fear I won't be accepted by my friends	19	(23.5)	2	(33.3)	NS
No one to care for my children	8	(9.9)	1	(16.7)	NS
No meetings/ programs in my area	17	(21.0)	2	(33.3)	NS
Anger from husband /partner/ boyfriend for Being abstinent	15	(18.5)	2	(33.3)	NS
Fear children could be taken away	5	(6.2)	1	(16.7)	NS
Not able to take time off work	10	(12.3)	2	(33.3)	NS
Living in a community where it is expected that I gamble	15	(18.5)	1	(16.7)	NS
Protected from the negative results of gambling	28	(34.6)	2	(33.3)	NS
Need to gamble to deal with the stress of daily life	59	(72.8)	4	(66.7)	NS

Note: Except where noted X²statistic was used and was non-significant (NS).

Table 9. (continued)

Treatment Barriers	Help from GA (n=81)		No Help from GA (n=6)		Statistic
	M	(SD)	M	(SD)	
Programmatic Characteristics Subscale Score	3.4	(4.4)	3.5	(5.0)	NS
Programmatic Characteristics:	n	(%)	n	(%)	
Not knowing what help is available in my area	36	(44.4)	4	(66.7)	NS
Having to wait for an opening in a formal treatment program	8	(9.9)	1	(16.7)	NS
Behavior of staff in formal treatment program	10	(12.3)	0	(0)	NS
Talk about problems with a male counselor	11	(13.6)	0	(0)	NS
Far distance of formal treatment program from my home	17	(21.0)	1	(16.7)	NS
No available transportation to treatment program	9	(11.1)	1	(16.7)	NS
Talking in a group where men are present	11	(13.6)	0	(0)	NS
Formal treatment programs that have men as well as women	7	(8.6)	0	(0)	NS
No treatment follow-up	7	(8.6)	2	(33.3)	NS
No confidence in formal treatment program to teach me what I need to know	17	(21.0)	1	(16.7)	NS
Lack of knowledge about gambling problem from staff	18	(22.2)	2	(33.3)	NS

Note: Except where noted X² statistic was used and was non-significant (NS).

Table 10 presents the barrier items that GA and non-GA members most frequently endorsed as being “a lot,” of a barrier to help seeking. The treatment barriers ‘gamble to deal with the stress of my daily life,’ ‘feeling ashamed to admit I have a gambling problem,’ and ‘feeling lonely without gambling in my life,’ were reported most often by both groups. In contrast, the individual barrier item ‘raised to believe I can take care of my own problems’ was identified by over 20% of those respondents involved in GA, yet, it was not identified at all (0%) by respondents who were not involved in GA.

Table 10. Percentage of Respondents Receiving Help and Not Receiving Help from GA Answering ‘A Lot’ to Perceived Barriers to Treatment

‘A Lot’ of a Treatment Barrier	Received Help from GA (n=81)		No Help from GA (n=6)	
	n	(%)	n	(%)
Gamble to deal with the stress of my daily life	32	(39.5)	3	(50.0)
Feeling ashamed to admit I have a gambling problem	28	(34.6)	3	(50.0)
Feeling lonely without gambling in my life	26	(32.1)	3	(50.0)
Afraid of what other will think of me if I get help	21	(25.9)	1	(16.7)
Feeling that gambling is not a problem for me	18	(22.2)	1	(16.7)
Raised to believe I can take care of my own problems	17	(21.0)	0	(0)
Not able to remain abstinent	13	(16.0)	2	(33.3)
Not knowing what help is available in my area	13	(16.0)	1	(16.7)

4.6.2 Treatment Barriers Among Respondents Who Received and Did Not Receive Formal Help

Another aim of this study was to explore the differences in treatment barriers identified by women who did and did not receive a formal type of help. Eighty-one percent (73 respondents) reported having received some type of formal help. Respondents who received formal treatment reported more individual barriers than respondents who had not received formal treatment (95% vs. 71%, $\chi^2=8.78$, $p<.01$). Respondents who received formal help had statistically higher total barriers scores than those not receiving formal help ($M=23.6$ vs. $M=13.5$, $(t_{(88)} = 2.35, p<.05)$). Formal treatment recipients also had statistically higher individual barrier mean subscale scores ($M= 10.8$ vs. $M=6.4$, $(t_{(88)} = 2.4, p<.05)$), and statistically higher socio-environmental barrier mean subscale scores ($M= 5.7$ vs. $M=2.5$, $(t_{(88)} = 2.8, p<.01)$). And, more formal treatment seekers compared to non-formal treatment seekers reported any (one or more) socio-environmental barrier (88% vs. 59%, $\chi^2=7.85$, $p<.01$).

Table 11 shows the barriers to treatment that statistically differed between those who received formal help and those who did not. Of the 4 barrier items that statistically related, 3 are individual and 1 is socio-environmental. Among the 17 respondents who did not ‘receive’ any formal help, 4 respondents reported that they ‘wanted’ formal help, while the remaining 13 respondents reported that they did ‘not want’ formal help. The results show that overall the four women who ‘wanted’ but did ‘not receive’ formal help perceived their greatest treatment barriers to be individual and socio-environmental issues and not programmatic ones. The individual and socio-environmental barriers endorsed by a majority of respondents who ‘wanted’ formal help but did ‘not receive’ formal help were: (1) Gamble to deal with stress in my daily life (100%); (2) Feeling ashamed to admit that gambling is a problem for me (75%); and (3) Feeling lonely without gambling in my life (75%). Further, the four women who ‘wanted’ formal help but did

‘not receive’ it, did not endorse the following 8 items as barriers to treatment and endorsed these items as ‘not at all’ of a barrier: (1) Not letting health problems interrupt my life (0%); (2) No one to care for my children (0%); (3) Fear kids will be taken away (0%); (4) Not able to take time off work (0%); (5) Having to wait for an opening in a formal treatment program (0%); (6) Behavior of staff in formal treatment program (0%); (7) No available transportation to treatment program (0%); and (8) No treatment follow-up (0%).

Table 11. Comparison of Statistically Related Treatment Barriers Among Women Who Did And Did Not Receive Formal Treatment

Treatment Barrier	Formal Help Received (n=73) n (%)	No Formal Help (n=17) n (%)	Statistic
Need to gamble to deal with the stress of daily life (Socio-environmental)	57 (78.1)	9 (52.9)	$X^2=4.5$, $p<.05$
Feeling lonely without gambling in my life (Individual)	53 (72.6)	8 (47.1)	$X^2=4.1$, $p<.05$
Raised to believe I should take care of my own problems (Individual)	47 (64.4)	6 (35.3)	$X^2=4.8$, $p<.05$
Being afraid of what people will think of me if I get help for my gambling problem (Individual)	46 (63.0)	5 (29.4)	$X^2=6.3$, $p<.05$

4.6.3 Survey Responses in Relation to Method of Survey Administration

When comparing the paper and pencil respondents (N=64) to the email respondents (N=26), frequency distributions showed minor differences between these two groups in relation to

demographic variables. Age of respondents and province/state where they reside were the only two demographic variables that were statistically related to the method of survey administration. Table 12 presents the demographic data. The average age of paper and pencil respondents was 51 years ($SD=10.4$), with most being between the ages of 41 and 65. Most paper and pencil respondents were white, married, and with children, although none had children residing with them. These women completed high school, community college or university, and were employed full time or were retired. For the email sample, the average age was 47 years ($SD=6.47$), with most being between the age of 41 and 55 years, white, and married. Most had children, but none had children living with them. The paper and pencil respondents were significantly older than the email respondents ($t(73) = 2.21, p < .05$). The majority of email respondents completed high school and were employed full-time. The majority of women in both samples reported personal incomes between \$15,000 and \$35,000; however, more women in the paper and pencil sample reported household incomes over \$80,000. The majority of paper and pencil respondents were from Ontario, no email respondents resided in Ontario, Canada. This difference was statistically significant ($\chi^2=48.83, p < .0001$).

Paper and pencil and email respondents did not differ statistically in relation to receipt of formal treatment, with the majority of both groups having received formal treatment (78% vs. 89%, respectively). These two groups differed statistically in relation to reporting that their depression was related to their gambling problem; more email than paper and pencil participants reported that their depression was related to their gambling (92% vs. 59%, $\chi^2=2.4, p < .01$).

Table 12. Demographic Information and Comparisons by Method of Survey Administration

Demographic Variables	Mail n (%)	Email n (%)	Statistical Analysis
<u>Age:</u>	<u>n=60</u>	<u>n=26</u>	
25 – 40	9 (15.0)	4 (15.4)	
41 – 55	31 (51.7)	19 (73.1)	
56 – 65	16 (26.7)	3 (11.5)	
66 – 80	4 (6.7)	0	
Average age (M/SD)	50.8 (10.4)	46.7 (6.5)	t=2.21, p<. 05
<u>Race/Ethnic Identity:</u>	<u>n=64</u>	<u>n=26</u>	NS
Caucasian	55 (85.9)	22 (84.6)	
Black/African American	6 (9.4)	0 (0)	
Other	3 (4.7)	4 (15.4)	
<u>New Race/Ethnic Identity Recode:</u>	<u>n=64</u>	<u>n=26</u>	NS
Caucasian	55 (85.9)	22 (84.6)	
Non-Caucasian	9 (14.1)	4 (15.4)	
<u>Marital Status:</u>	<u>n=64</u>	<u>n=26</u>	NS
Married/Cohabiting	32 (50.0)	18 (69.2)	
Divorced	12 (18.8)	4 (15.4)	
Single, Never Married	10 (15.6)	2 (7.7)	
Separated	6 (9.4)	1 (3.8)	
Widowed	4 (6.3)	1 (3.8)	
<u>New Marital Status Recode:</u>	<u>n=64</u>	<u>n=26</u>	NS
Married/Cohabiting	32 (50.0)	18 (69.2)	
Other	32 (50.0)	8 (30.8)	

Note: Except where noted, chi-square or t-test statistics were not significant (NS).

Table 12. (continued)

Demographic Variables	Mail n (%)	Email n (%)	Statistical Analysis
<u>Children:</u>	<u>n=64</u>	<u>n=26</u>	NS
Yes	50 (78.1)	19 (73.1)	
No	14 (21.9)	7 (26.9)	
<u>Number of Children Residing With Respondent:</u>	<u>n=64</u>	<u>n=26</u>	NS
0	50 (78.1)	20 (76.9)	
1	9 (14.1)	4 (15.4)	
2	4 (6.3)	1 (3.8)	
3	0	1 (3.8)	
4	1 (1.6)	0	
<u>New Children Recode:</u>	<u>n=64</u>	<u>n=26</u>	NS
No Children	50 (78.1)	20 (76.9)	
1 or More Children	14 (21.9)	6 (23.1)	
<u>Education Completed:</u>	<u>n=64</u>	<u>n=26</u>	NS
Elementary School	7 (10.9)	3 (11.5)	
High School	23 (35.9)	10 (38.5)	
Post Secondary	34 (53.1)	13 (50.0)	
<u>Employment:</u>	<u>n=64</u>	<u>n=26</u>	NS
Employed	42 (65.6)	18 (69.2)	
• Full-time	37 (57.8)	14 (53.8)	
• Part-time	3 (4.7)	3 (11.5)	
• Full-time and part-time	2 (3.1)	1 (3.8)	
Unemployed	4 (6.3)	4 (15.4)	
Homemaker	5 (7.8)	3 (11.5)	
Retired	11 (17.2)	0	
Disability	2 (3.1)	1 (3.8)	

Note: Except where noted, chi-square or t-test statistics were not significant (NS).

Table 12. (continued)

Demographic Variables	Mail n (%)	Email n (%)	Statistical Analysis
<u>New Employment Recode:</u>	<u>n=64</u>	<u>n=26</u>	NS
Employed	42 (65.6)	18 (69.2)	
Unemployed	22 (34.4)	8 (30.8)	
<u>Personal Income:</u>	<u>n=64</u>	<u>n=24</u>	NS
\$14,999 or less	11 (17.2)	6 (25.0)	
\$15,000 – \$34, 999	27 (42.2)	10 (41.7)	
\$35,000 - \$59,999	16 (25.0)	7 (29.2)	
\$60,000 - \$79,999	7 (10.9)	1 (4.2)	
Over \$80,000	3 (4.7)	0 (0)	
<u>New Personal Income Recode:</u>	<u>n=64</u>	<u>n=24</u>	NS
\$14,999 or less	11 (17.2)	6 (25.0)	
\$15,000 – \$34, 999	27 (42.2)	10 (41.7)	
\$35,000 - \$59,999	16 (25.0)	7 (29.2)	
\$60,000 +	10 (15.6)	1 (4.2)	
<u>Household Income:</u>	<u>n=62</u>	<u>n=25</u>	NS
\$14,999 or less	5 (8.1)	1 (4)	
\$15,000 – \$34, 999	15 (24.2)	6 (24)	
\$35,000 - \$59,999	20 (32.3)	6 (24)	
\$60,000 - \$79,999	11 (17.7)	7 (28)	
Over \$80,000	11 (17.7)	5 (20)	
<u>Province or State of Residence:</u>	<u>n=64</u>	<u>n=25</u>	$\chi^2=48.83, p<.0001$
Ontario	33 (51.6)	0	
Michigan	25 (39.1)	4 (16.0)	
Other	6 (9.4)	21 (84.0)	

Note: Except where noted, chi-square or t-test statistics were not significant (NS).

In terms of gambling severity, the GA20 score for email participants statistically differed from the GA20 score for paper and pencil participants ($M=18.3$ vs. $M=16.9$, $t_{(81)}=-2.49$, $p<.05$). Email participants also had higher SOGS total scores ($M=13.2$ vs. $M=12.3$) than paper and pencil respondents, however this result did not achieve statistical significance.

There were no statistical differences found between these two groups in relation to barriers to treatment. However, the email respondents had higher individual ($M=10.7$ vs. $M=9.5$), socio-environmental ($M=6.0$ vs. $M=4.7$), and programmatic ($M=4.3$ vs. $M=3.2$) barrier subscale scores, and higher total barriers scores overall ($M=23.3$ vs. $M=21.0$) than the paper and pencil participants. The majority of email participants (62%) identified that the socio-environmental barrier item ‘protected from the negative results of gambling’ presented some degree of a barrier to their getting treatment compared to the majority of paper and pencil respondents (77%) who identified it was not. This result was statistically significant ($X^2=11.89$, $p=.001$). No other statistical differences were found when these two groups were compared to whether or not the respondents reported one or more individual, socio-environmental and programmatic barriers to treatment.

4.6.4 Participants’ Final Comments

The final open-ended question asked: *Is there anything else you would like to say about this questionnaire or the problems you experienced in getting help for your gambling addiction?* Forty-one percent (37) responded to this question. Responses fell into two broad themes: treatment issues relating to experiences with various forms of formal and informal help, and issues about the questionnaire and/or study. Twenty seven percent referred to their involvement in GA, and one woman described it as an “excellent tool for preventing gambling.” One woman referred to the self-help mantra “one day at a time” and acknowledged “Gamblers Anonymous meetings work...if you want it to work.” Another respondent identified her treatment preference and stated, “No formal treatment plan worked for me. It took a 12-step program to show me the way.” Other women stated:

I never had a problem getting help from GA.
In the early years of my gambling it was virtually impossible to get formal help.
Only in the past few years has help been readily available but I have to fight to get into a treatment center.

All kinds of help are needed for compulsive gamblers, but I don't believe any of them would work without GA. It is the pivotal ingredient to recovery.

Two respondents noted the importance of Internet support, referring to their involvement with CGHub and requesting that Gamblers Anonymous 'sanction' online help as an available and effective treatment option. One respondent commented on her involvement with both formal and informal treatment and stated:

I do think that when I was ready, the help was there. I have had slips, and a treatment program probably would have helped me get abstinent quicker, but my HMO does not cover it to my knowledge. However, I do have a wonderful therapist who has special training in gambling addictions and I feel fortunate to get the help I need there, in GA meetings, and at the CGHub.

Almost half (46%) identified various issues that have affected help-seeking including their own treatment readiness; the far distance of treatment programs or Gamblers Anonymous meetings from their home; the lack of promotion and information about available treatment programs; the lack of awareness about the availability of help; and gender specific issues like wanting women-only meetings. One woman stated, "If I have to stay like this – torture, shaking, not sleeping, eating junk food. I wouldn't want to live...I can't handle the pain...stressed out from gambling." Other comments included:

I think that Q.76 (not knowing what help is available in my area) is the main reason that keeps me from seeking formal help.

You need on GA closer to where I live. I have to drive 45 minutes to a bad neighborhood to attend.

Most problem gamblers don't seek help because they are not ready to accept their life is unmanageable. The first step to recovery comes when we admit we are powerless over our addiction. No amount of assistance will be of use before we are ready to admit this to ourselves.

I just wish there were closer all-women meetings in my area. Sometimes there are things you can share in mixed company but there are lots of times where I feel I could only share things with another woman. And unfortunately there are so few women in meetings I attend so my chances of finding a sponsor are slim. Without a sponsor I am worried about my future recovery to continuing to grow.

Several women commented on the questionnaire and the study in general. Their comments included:

Personally I think that every question should have the option of having a slightly detailed answer. And also there are some questions that I considered did not apply to me personally (i.e. your last section on formal treatment, I didn't know that there was a formal treatment program ...until I attended a GA meeting ...

Good questionnaire. I and only I can decide I have a gambling problem and seek help.

I think that it is great someone has even considered female gamblers.

This survey was very well thought out to address women and gambling. There are many questions that were never asked of me as a woman. It is much more acceptable to be a man and gamble than a woman. It's time for a change in attitude in society.

5.0 CONCLUSIONS AND IMPLICATIONS

This study was designed to investigate the barriers women perceived or experienced in accessing help for their gambling addiction. All 90 women in this study self-identified as having a gambling problem, and the majority were involved with Gamblers Anonymous (GA). This research drew upon Boughton and Brewster's (2002) study of gambling and barriers to treatment conducted on an exclusively female sample.

This was the first study of treatment barriers conducted on women involved in GA and those accessing support on-line. It was also the first study to compare the differences in barriers to treatment among a women-only sample of gamblers who have accessed formal and informal treatment services. This study provides information on the individual issues, socio-environmental factors, and programmatic or structural characteristics that create barriers to treatment for women addicted to gambling. In this chapter I discuss the study's results in relation to current research and identify its implications for future research and treatment.

5.1 INTERPRETATION OF MAJOR FINDINGS

This study provides descriptive data that were self-reported and retrospective regarding women gamblers and their treatment experiences. Overall, the majority of respondents were middle aged ($M = 47$ years), Caucasian (86%), married or living with their partner (56%), and had children (77%). They had completed post-secondary education (52%), were employed full

and/or part-time (67%), had personal incomes between \$15,000 to \$34,999 (42%), and household incomes between \$35,000 to \$59,999 (30%). Most were recruited from the GA mini-conferences or by referral from other GA members (70%), and were living in Ontario, Canada (37%).

Treatment programs must address the increasingly complex issues experienced by women gamblers that impact their needs and strengths and the appropriateness and effectiveness of interventions. Setness (1997) wrote, “pathological gambling is typically a progressive disease, consisting of the winning phase, the losing phase and finally the desperation phase. Irritability and depression are common as long as losing and loss of control set in, and suicide becomes a real threat as debts build and the addiction affects family and professional life” (p.15). In this study, most (84%) reported feeling seriously depressed; 74% related their depression to gambling. Almost one-half of respondents (47%) were treated for a psychiatric or addictive disorder other than gambling; of which 60% sought treatment for depression. These data regarding depression are similar to other studies (Boughton & Brewster, 2002; Petry, Stinson, & Grant, 2005), and are higher than the prevalence rate of depression in women in Ontario (10-25%) (CAMH, 2002) or among the general U.S population (5.6 - 6.7%) (National Institute of Mental Health, 2006).

The findings in this study suggest considerable psychiatric comorbidity and raise concerns about the pervasiveness of problem gambling and its association with other problems. Petry, Stinson and Grant (2005) found women, compared to men, displayed stronger associations among several DSM-IV psychiatric disorders and pathological gambling. Petry et al.’s study suggested that compared to men, women may be more likely to develop pathological gambling in an attempt to alleviate an anxious and depressed mood. The strong association found between pathological gambling and alcohol dependence, any drug use disorder, nicotine dependence, major depressive disorder, and generalized anxiety disorder suggested that “women with these disorders may be a more deviant subgroup of the population and thus more highly comorbid for

recurrent maladaptive behaviors characteristic of addictive disorders” (Petry, Stinson & Grant, 2005, p. 571).

The National Council on Problem Gambling (1993) reported that 20% of pathological gamblers attempt suicide. My study found that over one-third (33%) reported having attempted suicide. Similar results have been reported in other studies of problem gamblers (Boughton & Brewster, 2003; Collins, Skinner & Toneatto, 2005). In this study, 57% related their suicide attempt to gambling, a result that is considerably higher than the 10% reporting suicidal thoughts and/or attempts related to gambling found in Boughton and Brewster’s (2002) study.

The involvement of women in this study in both formal and informal services to treat their gambling problem supports the claim that clients typically participate in more than one treatment modality (Amodeo, 1997). In this study, 81% reported having received some type of formal help for their gambling problems. In terms of specialized gambling treatment, 41% of the women in this study received crisis help, 27% received residential treatment services, and 43% received outpatient gambling treatment. All but one respondent (99%) reported having received some type of informal help. Ninety-one percent of respondents reported receiving help from GA and 38% received help from the Internet such as the support group CGHub. Ferentzy, Skinner and Antze (2003) suggested that female membership in GA is on the rise, and found that women represented between 10 to 30% of the membership. Petry (2003) found that individuals who had previous GA involvement were also more likely to become involved in professional therapy. Schober and Annis (1996) recommended that “a multi-modal treatment model would be more likely to emphasize women’s concerns and treatment needs, offer compatibility with women’s styles and orientations, as well as take into account women’s role expectations and experiences in society” (p. 87). Adopting a comprehensive model that identifies and adapts to the changing needs of women and improves the overall quality of life of women gamblers is consistent with social work’s practice principles of respect for human dignity and right to self-determination (DiNitto & McNeece, 1997).

1) *Identify the individual issues, socio-environmental factor, and programmatic characteristics that create barriers to treatment for women who have a gambling problem.*

These data suggest that individual factors, including emotional, psychological and personal issues, and socio-environmental issues, such as dealing with stress, were the most frequently endorsed barriers to treatment. The overall mean barriers score for the women in this study was 18.5 (SD=13.5). Correlations among the three barrier subscale were positive and statistically significant. Unlike Crisp et al. (2000), who suggested that child care, sexual assault, and domestic violence prevented women from seeking treatment, this study found that half or more of the women identified issues such as gambling to deal with stress in their life, feeling ashamed about admitting they have a problem, feeling lonely without gambling in their lives, raised to believe they should take care of their own problems, and being afraid of what others think if they get help.

Four out of the five top barriers identified in this study were individual factors. Similar to Evans and Delfabbro's (2005) finding, there was little evidence that the lack of knowledge or availability of a treatment program prevented the respondents in my study from getting help. In my study, Caucasian respondents reported significantly more individual barriers and had a higher individual barriers subscale score than non-Caucasian respondents. Those suffering from depression had statistically higher individual subscale scores than those who were not depressed. Finally, respondents who had attempted suicide reported statistically higher total barriers scores than the group of women who had not attempted suicide.

Boughton and Brewster (2002) found that psychological and emotional issues were key barriers to seeking treatment among their exclusively female sample of problem gamblers. Most common among their respondents (73%) was the tendency to be self-reliant in managing change and the belief that change should be made on their own. Similarly, Marotta (1999) found that factors such as denial, using one's own method, minimization of a problem, embarrassment and anxiety were the most frequently endorsed reasons for not seeking help. Failure to acknowledge

the need for treatment also emerged as important in the research conducted by Hodgins and el-Guebaly (2000), who found the majority of respondents, including those who were and were not still gambling, had never sought treatment for their gambling problems. Additionally, eighty percent of non-treated participants did not seek treatment because they thought they could ‘handle their gambling problems on their own without the use of formal treatment or self-help groups.’ Hodgins and el-Guebaly (2000) stated: “recovery from gambling is common, and it is likely that many of those who recover make these changes without treatment” (p. 778).

Evans and Delfabbro (2005) found personal attitudes to be the most significant barrier to seeking help. These barriers included: denial that a problem existed, a belief that the problem could be solved without external assistance, and an unwillingness to accept advice or stop gambling. Consistent with this, responses to an open-ended question in my study “What did you see as major barriers in seeking help for your gambling problem?” revealed that 50% of respondents reported denial, pride and embarrassment as the key factors to not seeking help.

In my study, significantly more respondents who reported they were depressed compared to those who were not, reported one or more socio-environmental barriers. More respondents who reported that their depression was related to gambling identified ‘gamble to deal with stress’ as a barrier compared to those who did not report that their depression was related to their gambling. Respondents reporting one or more social-environmental barriers had statistically higher SOGS total scores than those reporting no socio-environmental barriers. Almost all of the demographic variables were not statistically related to programmatic barriers; however respondents from other provinces and states had statistically higher programmatic barriers subscale mean scores than respondents from Ontario and Michigan.

The barriers identified least often by respondents in this study were: ‘fear that my children will be taken away if I get help’; ‘treatment program where both men and women are present’; ‘no treatment follow-up from formal treatment program to stay abstinent’; and, ‘having to wait for an opening in a formal treatment program because the program is full’.

2) Comparison of barriers identified by women actively involved in Gamblers Anonymous to those who were not

The majority (93%) of women in this study were involved with GA. Overall, GA members and non-members endorsed similar barriers to treatment. GA members reported a slightly lower total barriers score than non-GA members ($M=21.4$, $SD=16.4$ vs. $M=22.2$, $SD=15.9$). Non GA attendees had a higher mean socio-environmental barriers subscale score; a higher mean programmatic barriers subscale score; and a slightly lower mean individual barriers subscale score than GA attendees. Although these results were not statistically significant, the slightly higher individual barriers subscale score for GA attendees may suggest that individuals in treatment may have greater awareness of feelings, emotions and life issues. No statistically significant results were found when these groups were compared in terms of demographic variables or other variables.

The barriers endorsed by the majority of women in both groups as preventing them from getting help ‘a lot’ are: the socio-environmental barrier item ‘gamble to deal with the stress of my daily life,’ the individual barrier item ‘feeling ashamed to admit I have a gambling problem,’ the individual barrier item ‘feeling lonely without gambling in my life,’ and, the individual barrier item ‘afraid of what others will think of me if I get help.’ The programmatic barrier item ‘no treatment follow-up’ was the only barrier item that was significantly less of a treatment barrier for GA members compared to non-GA members. No other treatment barriers statistically differed in relation to those involved with GA compared to those who were not.

These findings are consistent with Evans and Delfabbro (2005), who found the most significant barriers to treatment were related to psychological issues and personal attitudes, including: denial, embarrassment, and the shame associated with acknowledging that a problem existed, as well as an unwillingness to accept advice or to stop gambling either because of a lack of motivation or adherence to the belief that gambling could resolve financial problems. The self-help group in Evans and Delfabbro’s (2005) study expressed greater concern for the

availability of alternative activities to take the place of gambling. For the self-help treatment seekers gambling provided an opportunity to ‘get out of the house.’

3) Comparison of differences between barriers to treatment among those respondents who received formal types of help with those who did not

Eighty-one percent (73 respondents) reported having received some type of formal help. Those receiving formal help reported more individual barriers than respondents who did not receive formal treatment, and had statistically higher total barriers scores, higher individual barrier subscale scores, higher socio-environmental barrier subscale scores, and more social environmental barriers than those who didn’t receive formal help.

The finding that women who had received formal treatment experienced or perceived more barriers to treatment than those who had not received formal treatment is counter-intuitive and was not an expected finding for this study. I anticipated that participants in formal treatment (or who had received formal treatment) would have lower mean barrier scores than participants who were not in formal treatment (or who had not received formal treatment). Treatment is intended to reduce problems. Evans and Delfabbro (2005) found that when compared to study participants who sought professional help, participants who received self-help statistically differed in relation to 4 barrier items (22% of total). Those who sought self-help were more reluctant to visit agencies that were faith-based, more concerned about what they would do in their spare time, more likely to identify life as ‘empty’ and ‘boring’ without gambling, and, more likely to perceive their social life as ‘dull’ because their friends were gamblers.

Possibly the women in this study who received formal treatment in this study were similar to the GA attendees in Petry’s study (2003), who represented gamblers at the most severe end of the addiction continuum and had sought treatment previously and failed. Perhaps, those who had experience with formal types of treatment were more aware of the obstacles one might encounter to getting such help. In contrast, those who haven’t sought formal treatment may be more naïve – unaware of the barriers that may exist. Prochaska and DiClemente’s (1986) stages

of change model proposes that behavior changes along a continuum and individuals also can regress back to earlier stages. Possibly, if individuals who have accessed formal treatment services experience more barriers than they would be more likely to revert back to earlier stages of precontemplation and contemplation. More research is needed to better understand the complex needs and problems of those seeking treatment. Effectively identifying and planning effective interventions is essential.

4) Comparing the responses of the two data collection methods used in this study: paper and pencil versus electronic mail.

The group of women who were administered the paper and pencil format of the questionnaire (N=64) and those who completed the survey by email (N=26) were similar on most demographic indicators, including race, marital status, number of children, level of education, employment status, and income. Differences between the email and the paper and pencil groups were not prominent. Age and residence were the only statistically significant results between these two groups. Email participants were on average younger than the paper and pencil respondents (47 yrs vs. 51 yrs), and the majority of paper and pencil respondents were from Ontario (52%), while no email participants were from Ontario.

The majority of both paper and pencil respondents (78%) and email respondents (89%) reported receiving formal types of help for their gambling problems. Online support offers privacy, convenience, safety and portability, and provides individuals who are concerned about stigma to seek help without making any personal disclosure (Cooper & Doucet, 2002).

Statistically more email participants reported that their depression was related to their gambling problems (92% vs. 59%, $X^2=2.4$, $p<.01$). These two groups also statistically differed regarding problem gambling severity. Email participants had higher GA20 scores than paper and pencil participants ($M=18.3$ vs. $M=16.9$, $t_{(81)}=-2.49$, $p<.05$). Email participants had higher SOGS score, higher individual, socio-environmental and programmatic barrier subscale scores, and higher total barriers scores than the paper and pencil participants; however, these results

were not statistically significant. These two group statistically differed in relation to the socio-environmental barrier item ‘protected from the negative results of gambling’; the majority of email participants (62%) identified this item as reflecting some degree of barrier to their getting treatment compared to the majority of paper and pencil respondents (77%) who reported that it was not a barrier to their acquisition of treatment ($\chi^2=11.89$, $p=.001$). No other statistical differences were found when email and paper-and-pencil participants were compared regarding having ‘no’ or ‘any’ individual, socio-environmental and programmatic barriers.

The open-ended responses in this study were in-depth and thought-provoking. Wood and Griffiths (2007) suggested that “online communication can lead to more emotional discourse and higher levels of personal disclosure than in face-to-face (FTF) settings” (p. 155). In general, in this study, email participants had lengthier responses (greater number of characters) than the paper and pencil participants. Studies comparing responses to open-ended questions on mail versus email surveys have reported that respondents completing email surveys provide longer responses (Schaeffer & Dillman, 1998). Similarly, Bachman, Elfrink, and Vazzana (1996) found that more respondents responded to a single open-ended question on an email survey than on a mail survey (22% vs. 5%, respectively).

5.2 METHODOLOGICAL ISSUES – STRENGTHS AND LIMITATIONS OF THIS STUDY

This study has inherent strengths and limitations. In general, this research contributed new information to the growing literature on gambling and, in particular, to the research on women gamblers. Although the subject of women gamblers is attracting more researchers’ attention, there is limited information available on barriers to treatment and about women who access informal help systems like Gamblers Anonymous or Internet self-help, the problems they

experience in accessing other forms of treatment, and their experience of recovery from their addiction to gambling.

In addition, the use of open-ended questions in this study allowed respondents to answer the questions asked of them in their own words. One respondent reported how pleased she was that the research focused exclusively on women. Another respondent hoped that by participating, she could help others who were struggling with similar issues. Future research should perhaps include more open-ended questions that delve further into the experiences of women gamblers.

A strength of this study was that it utilized a variety of strategies to recruit participants. I expected that using a variety of strategies would yield a higher number of participants. The recruitment of only women gamblers was a challenging undertaking and very time intensive. More women were recruited from the GA mini conferences (37%) and referral from key GA members (33%) than through any other strategy, including the Internet. Marotta (1999) acknowledged “there may be few rewards associated with self-identifying as a problem gambler, and problem gamblers...may avoid self-identifying as such” (p. 49). These concerns were mitigated by the use of an email format questionnaire, providing women gamblers the opportunity to share their experiences in the privacy, comfort, and safety of their own home, office, etc. Individuals’ feelings of shame and their denial of a problem can further impede research recruitment. These issues required me to actively recruit participants in a variety of ways, including referral by key GA members at GA sponsored events, and through the Internet. These recruitment efforts contributed to establishing rapport and added credibility to the study. I believe that the personal connection was an important factor and contributed to the high response yielded in venues where a key GA member or I was present. The personal connection made during recruitment, not only reinforced the human element in research, but, I believe, also helped to reduce systematic error, as participants would be less inclined to intentionally provide inaccurate responses after having had contact with either me or the key GA members.

The main limitation of this study was that the overall sample was small (N=90), and the Internet sample (n=26) was in particular, very small. The few statistically significant differences found in this study may be a reflection of the lack of adequate statistical power because of the small sample size.

A second limitation was the use of purposive sampling. The lack of random sampling weakens external validity, and the findings cannot be generalized to a larger population. Thus, it is not clear how representative these findings are of all women problem gamblers.

Third, the women who participated in this study were limited to those recruited from GA and the Internet; women not affiliated with GA or Internet support groups who are also problem gamblers were not included in this study. Future studies with heterogeneous samples are needed to assess the discriminative validity of the measures and to evaluate profile clusters.

Fourth, the data were derived from self-reported, retrospective accounts of respondents' problem gambling and their treatment experiences. Possibly, respondents minimized or exaggerated their experiences at the time the questionnaire was administered. Future research could include collaterals to permit data triangulation.

Finally, the reader is cautioned that the causal sequence between gambling and associated problems is not always clear. For example, to what extent do gambling problems lead to gambling problems and to what extent does gambling lead to depression? The increased prevalence of concurrent disorders raises the question of whether pathological gambling behavior masks other existing mental disorders, or, if pathological gambling is an outcome of other illnesses? Although the connection that the respondents make between their gambling and various adverse consequences appears to be quite plausible, one cannot be certain of a causal linkage with only cross-sectional data.

5.3 IMPLICATIONS FOR SOCIAL WORK

As of 2007, treatment for problem gambling is available across Canada. While gambling treatment programs are available in the United States, they have not kept pace with the proliferation of gambling venues across the country. It is likely, as gambling becomes more pervasive in our society, that social workers, regardless of the area in which they work, increasingly will be confronted with women experiencing problems associated with an addiction to gambling. “Social work’s response to vulnerability is to seek social change and to increase clients’ abilities to contend with difficult environments” (Gilgun, 1996, p. 399). Social work’s ecological systems perspective is particularly germane to understanding barriers to treatment. It focuses attention on both individual and social-environmental factors. The relationship between the woman gambler and the often complex context in which she lives can create sources of stress that, in turn, can create barriers to her help-seeking. Current treatment data suggests a diverse help-seeking population, reinforcing the need for treatment approaches that recognize the needs and strengths of clients in a variety of ways (Rush, 2002). The ecological systems perspective is ideal for developing treatment approaches that are concerned with more than the client’s gambling behavior. Treatment should be multi-disciplinary, comprehensive, coordinated, and one that works toward achieving a collaborative model to remove barriers, improve client-retention and provide continuing care and support (Ontario Ministry of Health and Long Term Care, 2005).

On the front line, social workers have a unique, first-hand opportunity to intervene and provide appropriate assessment and intervention. Castellani (2001), who supported a systems approach to treatment, wrote:

Psychiatrists need to adopt a systems approach to their treatment of patients. Even a cursory review of the literature reveals that pathological gambling is a rather complex and heterogeneous disorder. In order to provide the best treatment possible, psychiatrists need to conceptualize pathological gambling as a multiply

determined disorder that is complex in its pathogenesis and diagnostic features and equally complex in its negative outcomes. (p. 3)

Schools of social work do not require gambling addiction training in their curricula. Although addictions intervention is an important area of practice, social work students are inadequately prepared to identify or treat women with a gambling addiction. Schools of social work, particularly those located in urban settings where gambling venues are prevalent, should offer course work or integrate material about pathological gambling into the current curriculum. Efforts should also be made to educate the community at-large with regard to services offered.

Social work can play an important role in the treatment of problem and pathological gamblers. The majority of women in this study received help from both formal and informal treatment sources. This study did not investigate the best approach to treatment; however, these findings suggest that the women in this study sought help from various treatment modalities in various settings. Lesieur's (1998) argument that multiple treatment modalities should be considered given the clients configuration of problems, still applies today. Health Canada's (1999) Women's Health Strategy Report called upon health systems to gain an understanding of the distinct nature of women's health issues and address system biases and insensitivities to women and their issues.

Our health system has been slow to recognize that sex and gender are other significant determinants of health. For many years, a burgeoning women's health movement called attention to biases in the health system. At first, the sense that the system was failing women was intuitive and personal. Over time, awareness grew that shortfalls in the system were more pervasive and required comprehensive response - including changes in attitude and practice. (p. 6)

It is incumbent on social workers and others from the allied health professions to become better informed and better prepared to respond to clients with gambling problems. Women cope

with stress and life events in different ways and vary from men in how they signal their distress (Health Canada, 1999). These differences may have implications for the diagnoses and treatment women receive; therefore, it becomes necessary to raise awareness of the risks associated with problematic gambling behavior among those who may be experiencing gambling problems as well as those who have received treatment and are ambivalent about reengaging in treatment because of real or perceived barriers.

5.4 IMPLICATIONS FOR FUTURE RESEARCH

This research provided preliminary data on the factors that hinder help seeking among a sample of gambling addicted women. Toneatto, Boughton and Borsoi wrote “the lack of knowledge about female problem gamblers is of considerable importance as epidemiological studies in the United States and Canada indicate that women and men gamble at fairly similar rates in the general population” (2002, p. 3). I found that women gamblers turn to various interventions and support systems - both formal and informal treatment settings - to help with their gambling addiction. I expected to find that few women seek formal help; instead, I found the opposite. Marrota (1999) wrote:

In different functional ways, various influences and interventions, not necessarily delivered in treatment settings, interact with motivational factors to incrementally result in recoveries. This recovery process involves attitudinal changes, and reorientation of behaviors coupled with continued interactive factors. (p. 69)

More research to determine the effectiveness of different treatment modalities available to women gamblers is needed to optimize the allocation of health care resources.

An important public policy issue involves the possible effects of managed care contracts and health insurance policies in the United States. In Canada, treatment and prevention programs are firmly in place; however, the current system in the U.S places severe limits on

services for those with a pathological gambling disorder (National Research Council, 1999). Rush et al. (2005) suggested that “as gambling venues expand in a given jurisdiction, careful consideration should be given to expanding the treatment capacity and community awareness of treatment availability in equal proportion” (p. 32).

In 2002, Health Canada classified pathological gambling in the category ‘other co-occurring substance use and mental health disorders,’ and reported that there was insufficient evidence to provide best practice guidelines. Further inquiry is needed into the extent of comorbidity between pathological gambling and other mental disorders and substance abuse. There is a paucity of research regarding the natural course or response to treatment among pathological gamblers with comorbid disorders (Petry, Stinson, & Grant, 2005; Toneatto & Ladouceur, 2003). It is necessary to determine the nature of these associations in order to produce sustainable improvements.

Studies have identified socio-demographic variables as risk factors for pathological gambling (National Research Council, 1999; Petry, Stinson, & Grant, 2005; Shaffer, Hall & Vander Bilt, 1999). The finding in my study that women gamblers do experience barriers from their personal life, social environment, and from the treatment programs, suggests the need for further inquiry into the differential effects of variables such as gender, ethnicity, and socioeconomic status on barriers to treatment. Research that explores these relationships would provide information useful to engaging untreated individuals in treatment and to helping in relapse prevention. The women in this study were white, primarily middle class, employed, educated, and, for the most part, GA involved. Women from diverse backgrounds are addicted to gambling and experience problems associated with their gambling. Therefore, research is

needed to help us identify those strategies most responsive to the needs of these diverse groups of women.

Research conducted on exclusively female samples is critical in helping to improve access to treatment. Boughton (2003) wrote:

Counseling female gamblers requires a feminist sensitivity to the reality of women's lives...Supporting women through a process of making changes to their gambling can involve a variety of tasks in addition to relapse prevention: developing support systems, addressing relationship and leisure needs, working with financial issues, in dealing with psychiatric concerns or the aftermath of violence and trauma. (p. 14)

Social workers must understand women's experiences in order to provide competent assessment and treatment and provide appropriate referrals (Wilke, 1994). While programs need to be continually developed to meet the growing demand, attention to existing treatment programs is necessary to strengthen them and make them more accessible to women. Berry et al. (2002) wrote "many of the motivations for women's gambling are specific to gender and the roles of women in society. In light of the potential consequences for women arising from gambling, we must quickly begin to examine gambling by listening to what women themselves have to say" (p. 111).

Finally, the comparison of the administered (paper and pencil version) questionnaire with the email version yielded few differences. Although I experienced a relatively low response rate, given the popularity of the web-based self-help site I selected and the frequency of postings, I believe that further research attention should be devoted to understanding individuals who access Internet support. The Internet offers a good medium for conducting research with gamblers. Wood and Griffiths (2007) stated: "online research methods can be a useful way of examining the psychosocial aspects of gambling...They provide an extremely efficient way of gathering data and give the potential for large scale multinational studies to be performed...The main

disadvantages (e.g., potentially biased sample, validity issues, etc.) are in many ways no different to those encountered in more conventional research techniques” (p. 163). Data collection via the Internet is convenient, affordable, and accessible, and is worth of further inquiry.

5.5 CONCLUSION

This study was designed to provide a foundation for future research on access to treatment services by women addicted to gambling. The Ontario Problem Gambling Research Centre identified the issue of real and perceived barriers to treatment engagement as a priority research topic for fiscal 2005-2006, and is a study that is currently underway. This is an indication that the issue of barriers to treatment remains an important topic that requires further investigation. The problems that women addicted to gambling experience are captured in the following poem written by a study participant:

It rocks you gently like a summer breeze
You can come and go as you please
The excitement, the rush, is all you feel.
Your hopes and dreams seem so real.
It is your friend, your world with no ties.
The quiet demon that cheats and lies.
It finds the hole and fills it in.
Without mercy it will win.
And then with a fury that is wicked and mean,
You’ve done it again to the extreme
It raped your senses, your self-worth and more
It’s never enough, now what’s in store
You cover the lies, the web you have weaved,
Another day you have been deceived.
Stop the lies, the pain the bleeding
It won’t be long till he needs a feeding.
I’ll reach for help because I am weak,
The power to fight is what I seek.

To squash this demon that lies within
This day is mine he will not win!

It is my hope that this project's empirical observations provide information that will help to reduce and eliminate the barriers to treatment that exist for women gamblers.

APPENDIX A

PRINCIPAL INVESTIGATOR'S INITIAL CONTACT SCRIPT FOR RECRUITMENT AT GAMBLERS ANONYMOUS

Hello, may I speak to the person who runs the GA meeting at _____ (location of meeting). My name is Gina Bulcke, I am a doctoral candidate conducting a study to identify barriers that prevent women from getting help for their gambling problem. This research is being conducted under the auspices of the Ontario Problem Gambling Research Center and that University of Pittsburgh School of Social Work where I am doing this study as part of my doctoral work.

As you are well aware, we know very little about women gamblers, the problems they face and most especially the barriers they encounter when trying to get help for their addiction to gambling. I am interested in finding out this information.

I was hoping that I could come to the Gambler's Anonymous meeting at _____ (time and location of meeting), and describe my study to the members and then distribute questionnaires to all the women at the meeting. This research presents minimal risk to participants. Participation is anonymous, voluntary and confidential. Women not wanting to participate can do so without consequence. Women choosing to participate in the study will be asked to fill out the questionnaire and return it to me or mail it back in the self-addressed postage paid envelope that I provide. The questionnaire takes about 30 to 45 minutes to complete and consists of questions regarding demographics, addiction, mental health and treatment history, questions about their gambling problem (including the GA 20), and questions about the reasons that prevent women from getting help for their gambling problem.

My phone number and e-mail address, my supervisor's e-mail address and the phone number of the Human Subjects Protection Advocate at the University of Pittsburgh will be attached to the questionnaire so that if women have a problem, an issue or concern involving the study we can be reached.

I look forward to seeing you on _____ (confirm date).

Thank You

APPENDIX B

PRINICPAL INVESTIGATOR'S SCRIPT FOR INTRODUCING STUDY AND INFORMING PARTICIPANTS AT THE GAMBLERS ANONYMOUS MEETINGS

Hi Everyone,

Thank you for letting me come to talk to you about my study on women gamblers. This research is being conducted under the auspices of the Ontario Problem Gambling Research Council and the School of Social Work at the University of Pittsburgh. This study is part of my doctoral work. This study is for women only, 18 years of age or older, who have self-identified as having a gambling problem and are involved in self-help. This study is being conducted on women gamblers only because not a lot of research has been conducted on women.

The purpose of this study is to learn more about women gamblers by identifying the problems experienced in getting help for your gambling problem. By filling out the questionnaire you will help me learn about the problems you experience as a result of your gambling, and what if anything, kept you from getting help for your gambling. By being here at this Gambler's Anonymous meeting you recognize that you have or had a problem and that you needed help. I admire your courage.

If you agree to participate in this study, it will take you approximately 30 to 45 minutes to answer the questions on the questionnaire. You will be asked questions about your gambling problem, other addictions and mental health, your treatment history, some questions about your family of origin, demographic type questions (e.g. age, race, income) and specific questions about what, if anything, kept you from getting help for your gambling problem.

The risk is that the questions you will be asked are personal and you may feel a little uncomfortable. Every effort will be made to reduce any degree of discomfort you may experience. Remember, you can choose not to answer a question if you are uncomfortable with it. Also your identity and your right to confidentiality will be protected.

The benefit in participating in this study is that you will provide information that will hopefully help to eliminate problems like the ones you may have experienced in getting help for your gambling problem.

You will not incur any costs in participating in this study and you will not be paid to participate in this study.

All information you provide will be kept strictly confidential and anonymous. No identifying information is to be entered on any of the forms. Since **all information is completely anonymous**, no personal information about you or your family can ever be used in any way that can be identified. I do not know your name and no where is that asked of you on the questionnaire. If you choose to participate and fill out the questionnaire you have the option of returning the questionnaire to me at the end of the night or mailing it to the address on the manila envelope I provided. I have provided the postage for you in the event you decide to mail the questionnaire.

You are free to refuse to participate in this study; your participation is completely voluntary. Your participation, or your choice not to participate, is not related in any way to your involvement with Gambler's Anonymous or your participation in this Gambler's Anonymous meeting.

In the event that you have any questions or concerns pertaining to this research, feel free to contact me at by phone at (519) 979-1552 or by e-mail at gbulcke@hotmail.com or at the study's e-mail address at treatmentbarriers@hotmail.com. You can also contact Dr. Rafael Engel, School of Social Work, University of Pittsburgh by e-mail at engle@pitt.edu or the Human Subjects Protection Advocate at the University of Pittsburgh IRB Office at 412-578-4376.

Thank you very much for taking the time to do this study.

Gina Bulecke
Doctoral Candidate
School of Social Work
University of Pittsburgh

APPENDIX C

PRINCIPAL INVESTIGATOR'S SCRIPT FOR INTRODUCING STUDY AND INFORMING PARTICIPANTS AT THE GAMBLERS ANONYMOUS MINI- CONFERENCES

Dear Women Member of Gamblers Anonymous,

I recognize the courage it takes to recognize you have a gambling problem and get help. This study is for WOMEN ONLY, 18 years of age or older, who have a gambling problem.

I hope you will participate!

Thank you for taking the time to read this information and consider participating in this study on women gamblers during this wonderful conference. This research is being conducted under the auspices of the Ontario Problem Gambling Research Center and the School of Social Work at the University of Pittsburgh. This study is part of my doctoral work and is being conducted on women gamblers only because not a lot of research has been conducted on women.

The purpose of this study is to learn more about women gamblers by identifying the problems experienced in getting help for your gambling problem. By filling out the questionnaire you will help me learn about the problems you experience as a result of your gambling, and what if anything, kept you from getting help for your gambling.

If you agree to participate in this study, it will take you approximately 30 to 45 minutes to answer the questions on the questionnaire. You will be asked questions about your gambling problem, other addictions and mental health, your treatment history, some questions about your family of origin, demographic type questions (e.g. age, race, income) and specific questions about what, if anything, kept you from getting help for your gambling problem.

The risk is that the questions you will be asked are personal and you may feel a little uncomfortable. Every effort will be made to reduce any degree of discomfort you may experience. Remember, you can choose not to answer a question if you are uncomfortable with it and you may choose to terminate your participation in this study at any time.

The benefit in participating in this study is that you will provide information that will hopefully help to eliminate problems like the ones you may have experienced in getting help for your gambling problem.

You will not incur any costs in participating in this study and you will not be paid to participate.

All information you provide will be kept strictly confidential and anonymous. No identifying information is to be entered on any of the forms. Since **all information is completely anonymous**, no personal information about you or your family can ever be used in any way that can be identified. I do not know your name and no where is that asked of you on the questionnaire. If you choose to participate and fill out the questionnaire you have the option of returning the questionnaire to me by the end of the conference on Sunday, or mailing it back to me using the addressed manila envelope. I have provided the postage for you in the event you decide to mail the questionnaire.

You are free to refuse to participate in this study; your participation is completely voluntary. Your participation, or your choice not to participate, is not related in any way to your involvement with Gambler's Anonymous or your participation in this Gambler's Anonymous meeting.

In the event that you have any questions or concerns pertaining to this research, feel free to contact me by phone at (519) 979-1552 or by e-mail at gbulcke@hotmail.com or at the study's e-mail address at treatmentbarriers@hotmail.com. You can also contact Dr. Rafael Engel, School of Social Work, University of Pittsburgh by e-mail at engle@pitt.edu or the Human Subjects Protection Advocate at the University of Pittsburgh IRB Office at 412-578-4376.

Thank you very much for taking the time to participate in this study!

Gina Bulcke
Doctoral Candidate
School of Social Work
University of Pittsburgh

APPENDIX D

PRINCIPAL INVESTIGATOR'S SCRIPT FOR INTRODUCING STUDY AND INFORMING PARTICIPANTS FROM REFERRALS FROM KEY MEMBERS OF GAMBLERS ANONYMOUS

Dear Women Member of Gamblers Anonymous,

I recognize the courage it takes to recognize you have a gambling problem and get help. This study is for WOMEN ONLY, 18 years of age or older, who have a gambling problem.

I hope you will participate!

The person who gave you this package thought you might be interested in participating in this study. Thank you for taking the time to read this information and consider participating in this study on women gamblers. This research is being conducted under the auspices of the Ontario Problem Gambling Research Center and the School of Social Work at the University of Pittsburgh. This study is part of my doctoral work and is being conducted on women gamblers only because not a lot of research has been conducted on women.

The purpose of this study is to learn more about women gamblers by identifying the problems experienced in getting help for your gambling problem. By filling out the questionnaire you will help me learn about the problems you experience as a result of your gambling, and what if anything, kept you from getting help for your gambling.

If you agree to participate in this study, it will take you approximately 30 to 45 minutes to answer the questions on the questionnaire. You will be asked questions about your gambling problem, other addictions and mental health, your treatment history, some questions about your family of origin, demographic type questions (e.g. age, race, income) and specific questions about what, if anything, kept you from getting help for your gambling problem.

The risk is that the questions you will be asked are personal and you may feel a little uncomfortable. Every effort will be made to reduce any degree of discomfort you may experience. Remember, you can choose not to answer a question if you are uncomfortable with it and you may choose to terminate your participation in this study at any time.

The benefit in participating in this study is that you will provide information that will hopefully help to eliminate problems like the ones you may have experienced in getting help for your gambling problem.

You will not incur any cost in participating in this study and you will not be paid to participate.

All information you provide will be kept strictly confidential and anonymous. No identifying information is to be entered on any of the forms. **Since all information is completely anonymous**, no personal information about you or your family can ever be used in any way that can be identified. I do not know your name and no where is that asked of you on the questionnaire. If you choose to participate and fill out the questionnaire you have the option of returning the questionnaire to the key GA person who gave you the package (and they will forward it on to me) or mailing it to the address on the manila envelope I provided. Postage is also provided for your convenience.

You are free to refuse to participate in this study; your participation is completely voluntary. Your participation, or your choice not to participate, is not related in any way to your involvement with Gambler's Anonymous or your participation in this Gambler's Anonymous meeting.

In the event that you have any questions or concerns pertaining to this research, feel free to contact me by phone at (519) 979-1552 or by e-mail at gbulcke@hotmail.com or at the study's e-mail address at treatmentbarriers@hotmail.com. You can also contact Dr. Rafael Engel, School of Social Work, University of Pittsburgh by e-mail at engle@pitt.edu or the Human Subjects Protection Advocate at the University of Pittsburgh IRB office at 412-578-4376.

Thank you very much for taking the time to participate in this study!

Gina Bulcke
Doctoral Candidate
School of Social Work
University of Pittsburgh

APPENDIX E

PRINCIPAL INVESTIGATOR'S SCRIPT FOR E-MAIL RECRUITMENT, INTRODUCING THE STUDY, AND INFORMING PARTICIPANTS

Hi, I need your help!

My name is Gina Bulcke, and I am conducting a study on women gamblers. This research is being conducted under the auspices of the Ontario Problem Gambling Research Center and the School of Social Work at the University of Pittsburgh and is part of my doctoral work. This study is for WOMEN ONLY, 18 years of age or older, who have self-identified as having a gambling problem.

The purpose of this study is to learn more about women gamblers by identifying the problems experienced in getting help for your gambling. By filling out the questionnaire you will help me learn about the problems you experience as a result of your gambling, and what if anything, ever kept you from getting help. By logging on to this web site, you recognize that you have a problem and you may need help. I admire your courage.

If you agree to participate in this study, it will take you approximately 30 to 45 minutes to fill out the questionnaire. You will be asked questions about your gambling problem, other addictions and mental health, your treatment history, some questions about your family of origin, demographic type questions (e.g. age, race, income) and specific questions about what, if anything, kept you from getting help for your gambling problem.

If you agree to participate in this study, please contact me at treatmentbarriers@hotmail.com indicating that you are interested in participating by having me e-mail you the questionnaire. **Please do not use your first and last name at any time.** I suggest that you use the name and e-mail address that you use for the gambler's web site or you can make up a new one. You decide what is best for you. As you may already know, e-mail accounts (where you can use a pseudo name) are available for free at hotmail.com or yahoo.com.

The risk is that the questions you will be asked are personal and you may feel a little uncomfortable. Every effort will be made to reduce any degree of discomfort you may experience. Remember, you can choose not to answer a question if you are uncomfortable with it and you may choose to terminate your participation in this study at any time.

The benefit in participating in this study is that you will provide information that will hopefully help to eliminate problems like the ones you may have experienced in getting help for your gambling problem.

You will not incur any costs in participating in this study unless you decide to mail the questionnaire back to me instead of e-mailing it to me. If you mail the questionnaire to me you will have to cover the cost of postage. You will not be paid to participate in this study.

Once you have contacted me, I will send you the e-mail version of the questionnaire. By pressing 'reply', you can respond to the questions then by pressing 'send' or you can e-mail it back to me at treatmentbarriers@hotmail.com or you can make a hard copy and mail it back to me at Gina Bulcke - c/o 13300 Tecumseh Rd. E. Suite 368, Tecumseh, Ontario, Canada, N8N 4R8. (Remember: by mailing it to me you will have to cover the cost of postage).

All information you provide will be kept strictly confidential and anonymous. To ensure your anonymity, an honest broker is being used for this study. The honest broker is an individual who will separate returned questionnaires from e-mail addresses. The honest broker is a woman not connected to the study but a member of Gambler's Anonymous. The honest broker will provide me with only the completed questionnaires. She will destroy any identifying information including names (even a pseudo name), addresses etc. By using the honest broker **all information obtained will be completely anonymous**, and no personal information about you or your family can ever be used in any way that can be identified.

You are free to refuse to participate in this study; your participation is completely voluntary. Your participation, or your choice not to participate, is not related in any way to your involvement with this gambling self-help on-line forum.

In the event that you have any questions or concerns pertaining to this research, feel free to contact me at by phone at (519) 979-1552 or by e-mail at gbulcke@hotmail.com or at the study's e-mail address at treatmentbarriers@hotmail.com. You can also contact Dr. Rafael Engel, School of Social Work, University of Pittsburgh by e-mail at engle@pitt.edu or the Human Subjects Protection Advocate at the University of Pittsburgh IRB Office at 412-578-4376.

Thank you very much for taking the time to do this study!

Gina Bulcke

Doctoral Candidate

School of Social Work

University of Pittsburgh

APPENDIX F

ADMINISTERED QUESTIONNAIRE

Hello. Thank you for your interest and participating in this study. The purpose of this research is to learn more about you and the challenges you may have experienced in getting help for your gambling problem. This questionnaire should take about 30 minutes to complete. Please take your time.

Please answer the following questions as best you can. Thank you.

THIS FIRST SECTION ASKS QUESTIONS ABOUT YOUR SELF

1. How old are you? []

2. What was the highest level of education you have achieved?
[] Grade School
[] High School
[] College
[] University

3. What is your present employment status?
[] Employed full time (30 or more hrs/wk)
[] Employed part time (less than 30 hrs/wk)
[] Unemployed
[] Student - employed part or full time
[] Student - unemployed
[] Retired
[] Homemaker
[] Other (please specify) _____

4. Approximately, what is your personal net income per year?
[] \$0 - \$14,999
[] \$15,000 - \$34,999
[] \$35,000 - \$59,999
[] \$60,000 - \$79,999
[] \$80,000 and over

5. Approximately, what is your household net income per year?

- ☐ \$0 - \$14,999
- ☐ \$15,000 - \$34,999
- ☐ \$35,000 - \$59,999
- ☐ \$60,000 - \$79,999
- ☐ \$80,000 and over

6. What is your marital status?

- ☐ Married
- ☐ Living with Partner
- ☐ Separated
- ☐ Divorced (not remarried)
- ☐ Widowed (not remarried)
- ☐ Single

7. Do you have children?

- ☐ No
- ☐ Yes > If YES, how many children under 18 yrs live with you?

8. Please indicate how you describe your ethnic background.

Please mark one.

- ☐ African American/Black
- ☐ American Indian/Aboriginal/First Nations
- ☐ Black/Caribbean
- ☐ Latin/Hispanic
- ☐ East Asian (e.g. China, Vietnam, Thailand, Philippines, Japan)
- ☐ South Asian (e.g. India, Pakistan, Bangladesh, Sri Lanka)
- ☐ West Asian (e.g. Armenia, Iran, Syria, Turkey, Jordan, Israel)
- ☐ White (e.g. Canadian, American, British, German, Irish, Italian)
- ☐ Mixed Race
- ☐ Other, please specify _____

9. In what city and country do you currently live?

CITY _____ COUNTRY _____

THIS SECTION ASKS YOU QUESTIONS ABOUT YOUR GAMBLING

Please answer **each** question as best as you can.

10. When you gamble, how often do you go back another day to win back money you lost?

- ☐ Never
- ☐ Some of the time (less than half the time) I lost
- ☐ Most of the time I lost
- ☐ Every time I lost

11. Have you ever claimed to be winning money gambling but weren't really? In fact, you lost?

- ☐ Never (or never gamble)
- ☐ Yes, less than half the time I lost
- ☐ Yes, most of the time

12. Do you feel you have ever had a problem with gambling?

- ☐ No
- ☐ Yes, in the past, but not now
- ☐ Yes

13. Did you ever gamble more than you intended?

- ☐ Yes
- ☐ No

14. Have people ever criticized your gambling?

- ☐ Yes
- ☐ No

15. Have you ever felt guilty about the way you gamble or what happens when you gamble?

- ☐ Yes
- ☐ No

16. Have you ever felt like you would stop gambling but didn't think you could?

- ☐ Yes
- ☐ No

17. Have you ever hidden betting slips, lottery tickets, gambling money or other signs of betting or gambling from your spouse, children or other important people in your life?

- ☐ Yes
- ☐ No

18. Have you ever argued with people you live with over how you handle money?

- ☐ Yes > Go to Q. 19
- ☐ No > Go to Q. 20

19. (If you answered YES to Q. 18) Have money arguments ever centred on your gambling?

☐ Yes

☐ No

20. Have you ever borrowed from someone and not paid them back as a result of your gambling?

☐ Yes

☐ No

21. Have you ever lost time from work (or school) due to gambling?

☐ Yes

☐ No

22. If you borrowed money to gamble or pay gambling debts, in the past, who or where did you borrow from? (Please mark with an X, for **each**)

a. from household money

☐ Yes or ☐ No

b. from your spouse/partner

☐ Yes or ☐ No

c. from other relatives or in-laws

☐ Yes or ☐ No

d. from banks, loan companies, or credit unions

☐ Yes or ☐ No

e. from credit cards

☐ Yes or ☐ No

f. from loan sharks

☐ Yes or ☐ No

g. you cashed in stocks, bonds or other securities

☐ Yes or ☐ No

h. you sold personal or family property

☐ Yes or ☐ No

i. you borrowed on your checking account (passed bad cheques)

☐ Yes or ☐ No

j. you have had a line of credit with a bookie

☐ Yes or ☐ No

k. you have (had) a credit line with a casino

☐ Yes or ☐ No

23. Has gambling ever made your home life unhappy?

YES ☐ or NO ☐

24. Did gambling affect your reputation?

YES ☐ or NO ☐

25. Have you ever felt remorse after gambling?

YES ☐ or NO ☐

26. Did gambling cause a decrease in your ambition or energy?

YES ☐ or NO ☐

27. Did you ever gamble to get money to pay debts or solve some financial difficulty?

YES ☐ or NO ☐

28. Did you ever lose time from work due to gambling?

YES ☐ or NO ☐

29. After losing, did you feel you must return as soon as possible and win back your losses?

YES ☐ or NO ☐

30. After a win, did you have a strong urge to return and win more?

YES ☐ or NO ☐

31. Did you ever gamble until your last dollar was gone?

YES ☐ or NO ☐

32. Did you ever borrow to finance your gambling?

YES ☐ or NO ☐

33. Have you ever sold anything to finance your gambling?

YES ☐ or NO ☐

34. Were you ever reluctant to use "gambling money" for normal expenditures?

YES ☐ or NO ☐

35. Did gambling make you careless about the welfare of yourself and your family?

YES ☐ or NO ☐

36. Have you ever gambled to escape worry or trouble?

YES ☐ or NO ☐

37. Did you ever gamble longer than you had planned?

YES [] or NO []

38. Have you ever committed or considered committing an illegal act to finance your gambling?

YES [] or NO []

39. Has gambling ever caused you to have difficulty sleeping?

YES [] or NO []

40. Do arguments, disappointments, or frustration create the uncontrollable urge to gamble?

YES [] or NO []

41. Did you ever have an urge to celebrate good fortune by a few hours of gambling?

YES [] or NO []

42. Have you ever considered self-destruction as a result of gambling?

YES [] or NO []

43. Please, explain WHAT gambling did/is doing for you?

44. How long did/have you gamble(d)?

_____ month(s) or _____ year(s)

45. How long has gambling affected your life in negative ways?

_____ month(s) or _____ year(s)

46. How long has it been since you last gambled?

Please indicate with a number in the space provided

(e.g. 10 days or 2 years).

[] years

[] months

[] weeks

[] days

[] have not stopped gambling > Go to Q. 46a.

46a. (If you answered **have not stopped gambling** above in Q. 46) Why are you NOT trying to stop gambling?

Please explain.

47. What problems has your gambling caused you in your life? Please explain in the space provided.

48. This section asks you about formal help (e.g. residential, out-patient, medical, therapist/counsellor). For each question, please mark with an 'X' for YES or NO.

Residential (in-patient) treatment:

a. I wanted to get this kind of help

YES [] or NO []

b. I tried to get this kind of help

YES [] or NO []

c. I received this kind of help

YES [] or NO []

Out-patient treatment:

d. I wanted to get this kind of help

YES [] or NO []

e. I tried to get this kind of help

YES [] or NO []

f. I received this kind of help

YES [] or NO []

Psychiatric/medical help:

g. I wanted to get this kind of help

YES [] or NO []

h. I tried to get this kind of help

YES [] or NO []

i. I received this kind of help

YES [] or NO []

Private counseling/therapy:

j. I wanted to get this kind of help

YES [] or NO []

k. I tried to get this kind of help

YES [] or NO []

l. I received this kind of help

YES [] or NO []

Other: (please specify) _____

m. I wanted to get this kind of help

YES [] or NO []

n. I tried to get this kind of help

YES [] or NO []

o. I received this kind of help

YES [] or NO []

49. This section asks you about informal help e.g. GA, Internet). For each question, please mark with an 'X' for YES or NO.

Gambler's Anonymous > What step are you on? _____

a. I wanted to get this kind of help

YES [] or NO []

b. I tried to get this kind of help

YES [] or NO []

c. I received this kind of help

YES [] or NO []

Internet self-help: i.e. CGhub

d. I wanted to get this kind of help

YES [] or NO []

e. I tried to get this kind of help

YES [] or NO []

f. I received this kind of help

YES [] or NO []

Other self-help: please explain []

g. I wanted to get this kind of help

YES [] or NO []

h. I tried to get this kind of help

YES [] or NO []

i. I received this kind of help

YES [] or NO []

Support from family and/or friends:

j. I wanted to get this kind of help

YES [] or NO []

k. I tried to get this kind of help

YES [] or NO []

l. I received this kind of help

YES [] or NO []

Crisis hot-line

m. I wanted to get this kind of help

YES [] or NO []

n. I tried to get this kind of help

YES [] or NO []

o. I received this kind of help

YES [] or NO []

Other: (if this applies to you) please explain _____

p. I wanted to get this kind of help

YES [] or NO []

q. I tried to get this kind of help

YES [] or NO []

r. I received this kind of help

YES [] or NO []

50. Have formal services (e.g. residential, out-patient, psychiatric, therapist/counsellor) helped you with your gambling problem? Please mark the one that most applies to you and explain.

[] **YES**, please explain _____

[] **NO**, please explain _____

51. Have informal services (e.g. Gambler's Anonymous, other self-help, Internet, family/friends, etc.) helped you with your gambling problems? Please mark the one that most applies to you and explain.

☐ YES, please _____

☐ NO, please explain _____

52. Who recommended you get help for your gambling problem? Please mark with an 'X' all that apply.

☐ spouse/partner/boyfriend

☐ child(ren)

☐ family member

☐ friend

☐ employer

☐ medical doctor

☐ psychologist/therapist

☐ social worker

☐ social services

☐ myself

☐ other, please explain _____

53. Does your spouse/partner support you getting help for your gambling?

☐ Yes

☐ No > If NO, please explain why your spouse/partner does not support you getting help for your gambling problem _____

54. Who in your life also has (or had) a gambling problem? Please check all that apply.

☐ father

☐ mother

☐ brother or sister

☐ grandparent

☐ my partner(s)

☐ my child(ren)

☐ another relative

☐ a friend or someone else important in my life

THIS SECTION ASKS YOU QUESTIONS ABOUT ISSUES RELATED TO YOUR GAMBLING

55. Have you ever been treated for any other emotional/psychological/addictive disorder(s)?

☐ No > Go to Q. 56

☐ Yes > Go to 55a and 55b

55a. What were you treated for? _____

55b. Was what you were treated for related to gambling, drug or alcohol use?

Please mark all that apply.

☐ gambling

☐ drug use

☐ alcohol use

☐ none of these

56. Did your gambling problem surface during the course of other treatment?

☐ YES

☐ NO

57. Have you ever felt seriously depressed?

☐ No

☐ Yes > If YES, was your depression related to gambling, drug or alcohol use?

Please mark all that apply.

☐ gambling

☐ drug use

☐ alcohol use

☐ none of these

58. Have you ever attempted suicide?

☐ No

☐ Yes > If YES, was your suicide attempt related to gambling, drug or alcohol use? **Please mark all that apply.**

☐ gambling

☐ drug use

☐ alcohol use

☐ none of these

THIS FINAL SECTION ASKS YOU QUESTIONS ABOUT GETTING HELP FOR YOUR GAMBLING PROBLEM

Listed below are reasons that may keep women from getting help

Based on what you have experienced or are experiencing or perceive to be true, how much has each of the following reasons EVER kept you from getting help for your gambling problem? For each statement below, please mark only one with an 'X' in the space provided.

59. Feeling ashamed to admit I have a gambling problem, has kept me from getting help...

A Lot ☐ Somewhat ☐ A Little ☐ Not At All ☐

60. Not being able to remain abstinent from gambling after getting help, has kept me from getting help ...

A Lot ☐ Somewhat ☐ A Little ☐ Not At All ☐

61. Not able to afford the costs associated with getting help, has kept me from getting help...

A Lot ☐ Somewhat ☐ A Little ☐ Not At All ☐

62. Not having health insurance to cover the costs of getting help, has kept me from getting help...

A Lot ☐ Somewhat ☐ A Little ☐ Not At All ☐

63. Not trusting that doctors, clinics or hospitals can help me, has kept me from getting help ...

A Lot[] Somewhat[] A Little[] Not At All[]

64. Feeling that gambling is not a problem for me, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

65. Not letting health problems interrupt my life, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

66. Having responsibilities at home as a mother, wife, or partner, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

67. Raised to believe I should take care of my own problems, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

68. Feeling lonely without gambling in my life, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

69. Being afraid of what people will think of me if I get help for my gambling, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

70. Is there anything else in your personal life that has affected you getting help for your gambling problems? Please explain here.

Based on what you have experienced or are experiencing or what you perceive to be true, how much have the following reasons EVER kept you from getting help for your gambling problems. For each statement below, please mark only one with an 'X' in the space provided.

71. No encouragement from family and friends to get help for my gambling problem, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

72. Fear that I won't be accepted by my friends if I am abstinent, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

73. Having no one to take care of my children while I get help, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

74. Having no meetings or programs in my area to help me stay abstinent, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

75. Anger from my husband, partner, boyfriend for being abstinent, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

76. The fear that if I admit that I have this problem it could be used to take my children away, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

77. Not being able to get time off from work to get help, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

78. Living in a community where it is expected that you gamble, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

79. Being protected from the negative results of my gambling addiction from my family, friends, or coworkers, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

80. Needing to gamble to deal with the stress of my daily life, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

81. What other issues in your life have kept you from getting help for your gambling problems?

Based on what you have experienced or are experiencing or perceive to be true, how much has each of the following issues about formal treatment programs has EVER kept you from getting help for your gambling problem? For each statement below, please mark only one with an 'X' in the space provided.

82. Not knowing what help is available in my area, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

83. Having to wait for an opening in a formal treatment program because the program is full, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

84. The behaviour of staff toward patients in formal treatment programs has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

85. Possibly having to talk about my problem with a male counsellor, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

86. The far distance of formal treatment programs from my home, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

87. No available transportation to formal treatment programs, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

88. Possibly having to talk in a group where men are present, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

89. Formal treatment programs that have men as well as women, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

90. No treatment follow-up from formal treatment programs to stay abstinent, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

91. No confidence in formal treatment programs to teach me what I need to know as a gambling addicted woman, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

92. The lack of knowledge about gambling problems from staff in formal treatment programs, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

93. Is there any thing else you would like to say about this questionnaire, or the problems you have ever experienced in getting help for your gambling problem?
Please explain.

END. I want to thank you very much for your help!!

APPENDIX G

E-MAIL QUESTIONNAIRE

Hello. Thank you for your interest and participating in this study. The purpose of this research is to learn more about you and the challenges you may have experienced in getting help for your gambling problem. This questionnaire should take about 30 minutes to complete. Please take your time.

Please answer the following questions as best you can. Please be aware that brackets '[']' will w-i-d-e-n and the space provided to answer questions will lengthen. To answer please press 'reply' then type in your answers in the space provided for each question. Then press send. Thank you.

THIS FIRST SECTION ASKS QUESTIONS ABOUT YOUR SELF

1. How old are you? []

2. What was the highest level of education you have achieved?
[] Grade School
[] High School
[] College
[] University

3. What is your present employment status?
[] Employed full time (30 or more hrs/wk)
[] Employed part time (less than 30 hrs/wk)
[] Unemployed
[] Student - employed part or full time
[] Student - unemployed
[] Retired
[] Homemaker
[] Other (please specify) []

4. Approximately, what is your personal net income per year?

- ☐ \$0 - \$14,999
- ☐ \$15,000 - \$34,999
- ☐ \$35,000 - \$59,999
- ☐ \$60,000 - \$79,999
- ☐ \$80,000 and over

5. Approximately, what is your household net income per year?

- ☐ \$0 - \$14,999
- ☐ \$15,000 - \$34,999
- ☐ \$35,000 - \$59,999
- ☐ \$60,000 - \$79,999
- ☐ \$80,000 and over

6. What is your marital status?

- ☐ Married
- ☐ Living with Partner
- ☐ Separated
- ☐ Divorced (not remarried)
- ☐ Widowed (not remarried)
- ☐ Single

7. Do you have children?

- ☐ No
- ☐ Yes > If YES, how many children under 18 yrs live with you?

8. Please indicate how you describe your ethnic background.
Please mark one.

- ☐ African American/Black
- ☐ American Indian/Aboriginal/First Nations
- ☐ Black/Caribbean
- ☐ Latin/Hispanic
- ☐ East Asian (e.g. China, Vietnam, Thailand, Philippines, Japan)
- ☐ South Asian (e.g. India, Pakistan, Bangladesh, Sri Lanka)
- ☐ West Asian (e.g. Armenia, Iran, Syria, Turkey, Jordan, Israel)
- ☐ White (e.g. Canadian, American, British, German, Irish, Italian)
- ☐ Mixed Race
- ☐ Other, please specify

9. In what city and country do you currently live?

CITY [] COUNTRY []

THIS SECTION ASKS YOU QUESTIONS ABOUT
YOUR GAMBLING.

Please answer each question as best as you can.

10. When you gamble, how often do you go back
another day to win back money you lost?

- ☐ Never
- ☐ Some of the time (less than half the time
I lost)
- ☐ Most of the time I lost
- ☐ Every time I lost

11. Have you ever claimed to be winning money
gambling but weren't really? In fact, you lost?

- ☐ Never (or never gamble)
- ☐ Yes, less than half the time I lost
- ☐ Yes, most of the time

12. Do you feel you have ever had a problem with
gambling?

- ☐ No
- ☐ Yes, in the past, but not now
- ☐ Yes

13. Did you ever gamble more than you intended?

- ☐ Yes
- ☐ No

14. Have people ever criticized your gambling?

- ☐ Yes
- ☐ No

15. Have you ever felt guilty about the way you
gamble or what happens when you gamble?

- ☐ Yes
- ☐ No

16. Have you ever felt like you would stop gambling
but didn't think you could?

- ☐ Yes
- ☐ No

17. Have you ever hidden betting slips, lottery tickets, gambling money or other signs of betting or gambling from your spouse, children or other important people in your life?

☐ Yes

☐ No

18. Have you ever argued with people you live with over how you handle money?

☐ Yes > Go to Q. 19

☐ No > Go to Q. 20

19. (If you answered YES to Q. 18) Have money arguments ever centred on your gambling?

☐ Yes

☐ No

20. Have you ever borrowed from someone and not paid them back as a result of your gambling?

☐ Yes

☐ No

21. Have you ever lost time from work (or school) due to gambling?

☐ Yes

☐ No

22. If you borrowed money to gamble or pay gambling debts, in the past, who or where did you borrow from? Please mark with an X, for each)

a. from household money

☐ Yes or ☐ No

b. from your spouse/partner

☐ Yes or ☐ No

c. from other relatives or in-laws

☐ Yes or ☐ No

d. from banks, loan companies, or credit unions

☐ Yes or ☐ No

e. from credit cards

☐ Yes or ☐ No

f. from loan sharks

☐ Yes or ☐ No

g. you cashed in stocks, bonds or other securities

☐ Yes or ☐ No

h. you sold personal or family property

☐ Yes or ☐ No

i. you borrowed on your checking
account (passed bad cheques)

☐ Yes or ☐ No

j. you have had a line of credit
with a bookie

☐ Yes or ☐ No

k. you have (had) a credit line
with a casino

☐ Yes or ☐ No

23. Has gambling ever made your home life unhappy?

YES ☐ or NO ☐

24. Did gambling affect your reputation?

YES ☐ or NO ☐

25. Have you ever felt remorse after gambling?

YES ☐ or NO ☐

26. Did gambling cause a decrease in your
ambition or energy?

YES ☐ or NO ☐

27. Did you ever gamble to get money to
pay debts or solve some financial difficulty?

YES ☐ or NO ☐

28. Did you ever lose time from work due
to gambling?

YES ☐ or NO ☐

29. After losing, did you feel you must
return as soon as possible and win back
your losses?

YES ☐ or NO ☐

30. After a win, did you have a strong urge to return and win more?
YES [] or NO []
31. Did you ever gamble until your last dollar was gone?
YES [] or NO []
32. Did you ever borrow to finance your gambling?
YES [] or NO []
33. Have you ever sold anything to finance your gambling?
YES [] or NO []
34. Were you ever reluctant to use "gambling money" for normal expenditures?
YES [] or NO []
35. Did gambling make you careless about the welfare of yourself and your family?
YES [] or NO []
36. Have you ever gambled to escape worry or trouble?
YES [] or NO []
37. Did you ever gamble longer than you had planned?
YES [] or NO []
38. Have you ever committed or considered committing an illegal act to finance your gambling?
YES [] or NO []
39. Has gambling ever caused you to have difficulty sleeping?
YES [] or NO []
40. Do arguments, disappointments, or frustration create the uncontrollable urge to gamble?
YES [] or NO []
41. Did you ever have an urge to celebrate good fortune by a few hours of gambling?
YES [] or NO []

42. Have you ever considered self-destruction as a result of gambling?

YES [] or NO []

43. Please, explain WHAT gambling did/is doing for you?

[]

44. How long did/have you gamble(d)?

[]month(s) or []year(s)

45. How long has gambling affected your life in negative ways?

[]month(s) or []year(s)

46. How long has it been since you last gambled?

Please indicate with a number in the space provided (e.g. 10 days or 2 years).

[] years

[] months

[] weeks

[] days

[] have not stopped gambling > Go to Q. 46a.

46a. (If you answered have not stopped gambling above in Q. 46) Why are you NOT trying to stop gambling?

Please explain.

[]

47. What problems has your gambling caused you in your life? Please explain in the space provided.

[]

48. This section asks you about formal help

(e.g. residential, out-patient, medical, therapist/counsellor). For each question, please mark with an 'X' for YES or NO.

Residential (in-patient) treatment:

a. I wanted to get this kind of help

YES [] or NO []

b. I tried to get this kind of help

YES [] or NO []

c. I received this kind of help

YES [] or NO []

Out-patient treatment:

d. I wanted to get this kind of help

YES [] or NO []

e. I tried to get this kind of help

YES [] or NO []

f. I received this kind of help

YES [] or NO []

Psychiatric/medical help:

g. I wanted to get this kind of help

YES [] or NO []

h. I tried to get this kind of help

YES [] or NO []

i. I received this kind of help

YES [] or NO []

Private counselling/therapy:

j. I wanted to get this kind of help

YES [] or NO []

k. I tried to get this kind of help

YES [] or NO []

l. I received this kind of help

YES [] or NO []

Other: (please specify)[]

m. I wanted to get this kind of help

YES [] or NO []

n. I tried to get this kind of help

YES [] or NO []

o. I received this kind of help

YES [] or NO []

49. This section asks you about informal help

e.g. GA, Internet). For each question,
please mark with an 'X' for YES or NO.

What step are you on? []

a. I wanted to get this kind of help
YES [] or NO []

b. I tried to get this kind of help
YES [] or NO []

c. I received this kind of help
YES [] or NO []

Internet self-help: i.e. CGHub

d. I wanted to get this kind of help
YES [] or NO []

e. I tried to get this kind of help
YES [] or NO []

f. I received this kind of help
YES [] or NO []

Other self-help: please explain []

g. I wanted to get this kind of help
YES [] or NO []

h. I tried to get this kind of help
YES [] or NO []

i. I received this kind of help
YES [] or NO []

Support from family and/or friends:

j. I wanted to get this kind of help
YES [] or NO []

k. I tried to get this kind of help
YES [] or NO []

l. I received this kind of help
YES [] or NO []

Crisis hot-line

m. I wanted to get this kind of help
YES [] or NO []

n. I tried to get this kind of help
YES [] or NO []

o. I received this kind of help

YES [] or NO []

Other: (if this applies to you) please explain

[]

p. I wanted to get this kind of help

YES [] or NO []

q. I tried to get this kind of help

YES [] or NO []

r. I received this kind of help

YES [] or NO []

50. Have formal services (e.g. residential, out-patient, psychiatric, therapist/counsellor) helped you with your gambling problem? Please mark the one that most applies to you and explain.

[] YES, please explain

[]

[] NO, please explain

[]

51. Have informal services (e.g. Gamblers Anonymous, other self-help, Internet, family/friends, etc.) helped you with your gambling problems? Please mark the one that most applies to you and explain.

[] YES, please

[]

[] NO, please explain

[]

52. Who recommended you get help for your gambling problem? Please mark with an 'X' all that apply.

[] spouse/partner/boyfriend

[] child(ren)

[] family member

[] friend

[] employer

[] medical doctor

[] psychologist/therapist

- ☐ social worker
☐ social services
☐ myself
☐ other, please explain []

53. Does your spouse/partner support you getting help for your gambling?

- [] Yes
[] No > If NO, please explain why your spouse/partner does not support you getting help for your gambling problem
[_____]

54. Who in your life also has (or had) a gambling problem? Please check all that apply.

- [] father
- [] mother
- [] brother or sister
- [] grandparent
- [] my partner(s)
- [] my child(ren)
- [] another relative
- [] a friend or someone else important in my life

THIS SECTION ASKS YOU QUESTIONS ABOUT ISSUES
RELATED TO YOUR GAMBLING

55. Have you ever been treated for any other emotional/psychological/addictive disorder(s)?

- [] No > Go to Q. 56
[] Yes > Go to 55a and 55b

55a. What were you treated for? []

55b. Was what you were treated for related to gambling, drug or alcohol use?
Please mark all that apply.

- [] gambling
- [] drug use

- ☐ alcohol use
- ☐ none of these

56. Did your gambling problem surface during the course of other treatment?

- ☐ YES
- ☐ NO

57. Have you ever felt seriously depressed?

- ☐ No
- ☐ Yes > If YES, was your depression related to gambling, drug or alcohol use?

Please mark all that apply

- ☐ gambling
- ☐ drug use
- ☐ alcohol use
- ☐ none of these

58. Have you ever attempted suicide?

- ☐ No
- ☐ Yes > If YES, was your suicide attempt related to gambling, drug or alcohol use? Please mark all that apply.

- ☐ gambling
- ☐ drug use
- ☐ alcohol use
- ☐ none of these

THIS FINAL SECTION ASKS YOU QUESTIONS ABOUT GETTING HELP FOR YOUR GAMBLING PROBLEM

Listed below are reasons that may keep women from getting help. Based on what you have experienced or are experiencing or perceive to be true, how much has each of the following reasons EVER kept you from getting help for your gambling problem? For each statement below, please mark only one with an 'X' in the space provided.

59. Feeling ashamed to admit I have a gambling problem, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

60. Not being able to remain abstinent from gambling after getting help, has kept me from getting help ...

A Lot[] Somewhat[] A Little[] Not At All[]

61. Not able to afford the costs associated with getting help, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

62. Not having health insurance to cover the costs of getting help, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

63. Not trusting that doctors, clinics or hospitals can help me, has kept me from getting help ...

A Lot[] Somewhat[] A Little[] Not At All[]

64. Feeling that gambling is not a problem for me, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

65. Not letting health problems interrupt my life, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

66. Having responsibilities at home as a mother, wife, or partner, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

67. Raised to believe I should take care of my own problems, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

68. Feeling lonely without gambling in my life, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

69. Being afraid of what people will think of me if I get help for my gambling, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

70. Is there anything else in your personal life that has affected you getting help for your gambling problems? Please explain here.

[]

Based on what you have experienced or are experiencing or what you perceive to be true, how much have the following reasons EVER kept you from getting help for your gambling problems. For each statement below, please mark only one with an 'X' in the space provided.

71. No encouragement from family and friends to get help for my gambling problem, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

72. Fear that I won't be accepted by my friends if I am abstinent, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

73. Having no one to take care of my children while I get help, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

74. Having no meetings or programs in my area to help me stay abstinent, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

75. Anger from my husband, partner, boyfriend for being abstinent, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

76. The fear that if I admit that I have this problem it could be used to take my children away, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

77. Not being able to get time off from work to get help, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

78. Living in a community where it is expected that you gamble, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

79. Being protected from the negative results of my gambling addiction from my family, friends, or coworkers, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

80. Needing to gamble to deal with the stress of my daily life, has kept me from getting help...
A Lot[] Somewhat[] A Little[] Not At All[]

81. What other issues in your life have kept you from getting help for your gambling problems?

Based on what you have experienced or are experiencing or perceive to be true, how much has each of the following issues about formal treatment programs has EVER kept you from getting help for your gambling problem?

For each statement below, please mark only one with an 'X' in the space provided.

82. Not knowing what help is available in my area, has kept me from getting help...
A Lot[] Somewhat[] A Little[] Not At All[]

83. Having to wait for an opening in a formal treatment program because the program is full, has kept me from getting help...
A Lot[] Somewhat[] A Little[] Not At All[]

84. The behaviour of staff toward patients in formal treatment programs has kept me from getting help...
A Lot[] Somewhat[] A Little[] Not At All[]

85. Possibly having to talk about my problem with a male counsellor, has kept me from getting help...
A Lot[] Somewhat[] A Little[] Not At All[]

86. The far distance of formal treatment programs from my home, has kept me from getting help...
A Lot[] Somewhat[] A Little[] Not At All[]

87. No available transportation to formal treatment programs, has kept me from getting help...
A Lot[] Somewhat[] A Little[] Not At All[]

88. Possibly having to talk in a group where men are present, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

89. Formal treatment programs that have men as well as women, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

90. No treatment follow-up from formal treatment programs to stay abstinent, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

91. No confidence in formal treatment programs to teach me what I need to know as a gambling addicted woman, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

92. The lack of knowledge about gambling problems from staff in formal treatment programs, has kept me from getting help...

A Lot[] Somewhat[] A Little[] Not At All[]

93. Is there any thing else you would like to say about this questionnaire, or the problems you have ever experienced in getting help for your gambling problem? Please explain.

[]

END. I want to thank you very much for your help!!

APPENDIX H

PARTICIPANT RESPONSES TO OPEN-ENDED QUESTIONS

I.D	1	Response
		Allowed me to escape reality as long as I was in the casino gambling I chased loneliness
		Finances in bad shape, 401K gone, and equity line of credit on home gone and no savings.
		NO. When I was in counseling I was not ready to quit gambling, so no help, we talked about GA but I did not go at that time.
		YES, meetings (GA) sharing with other people with same problem.
		Boredom when not gambling
		I am a recovering alcoholic, and a number of the questions were not true for me because I am in AA, so I knew I needed GA to stop gambling!
I.D	2	Response
		It was an escape. While at the casino or bingo hall 99% of the time I forgot everything but gambling.
		Loss of family - daughter left home due to financial situation. Loss of family home - can't pay the bills. Bankruptcy - chapter 13, credit ruined.
		Yes, Gambler's Anonymous, attending meeting, twelve steps, members.
		Being in denial of the problem
I.D	3	Response
		Can't say how many times I returned the following day to chase what I lost.
		every penny in my pocket and from my bank account
		I knew I wanted to stop, didn't know how until GA

	What I did is not borrow it was down right thievery, taking from the bill money only to replace it later, taking from my ex-spouses wallet or even his vacation account without replacing it until I got caught
	At the time I was a self employed manicurist upon occasion I was a few minutes late for an appointment, most of the time when I had free time on my books I would disappear to gamble so in turn I would miss a potential new client that would call the front desk or walk in. I've cut college course only to wind up dropping them because of too many missed days.
	Gambling...didn't do a thing for me. What it created was distrust from spouse, became a liar, cheat, thief, felt guilty all the time, money arguments, low self esteem, low self confidence, an escape artist from all of life's responsibilities, created greed, became manipulatory, sarcastic, and basically humorless, had "the world is out to get me" attitude or "I'm owed something in this life" Towards the end of my gambling career it's not that I wanted to commit suicide, I just wanted all to disappear around me like I never existed to begin with.
	NO, never used formal services
	YES, for me GA has been the best help. I can relate to the stories of others because for the most part they are similar to me experience gambling. Can relate quite well to the emotionalism and feelings that go along on that mental roller coaster ride. In the beginning of my Internet use with the CGHub I considered the hub as a supplementary tool to the GA program and my recovery. Now the HUB for me has become much more that as I have made a few close friends that make up part of my support group. With exception of my former spouse, who was not very supportive from the beginning, my friends and family have been very supportive. Through this program I have a better relationship with my brother; the relationship with my parents has grown stronger. The few close friends that I have been very supportive of my abstinence and recovery and have a basic understanding as to why I choose to do this program. GA FOR ME IS A LIFE GIVER, it has given me a chance to continue on with my life as "normally" as possible without pacing a bet.
	My ex-spouse was very unsupportive of my receiving the help that I deserve to overcome my gambling problem. He used to tell me that if I really wanted to stop I could and it starts in here, tapping himself on the chest over his heart and tapping his head. And I believe what he said, that basically I didn't need any support to stop. Finally when I did get into a support group, GA, I was able to stop. I cannot say that I will never go back to gambling, What I can say is I have stopped gambling ONE DAY AT A TIME. I can handle one day a lot better that I can handle an eternity.

	Personally I think that every question should have the option of having a slightly detailed answer. And also there are some questions that I considered that did not apply to me personally (i.e. your last section in formal treatment, I didn't know that there was formal treatment program such as IOP until I attended a GA meeting. P.S. If you want a really good interview you may want to contact Dr. Hunter, He is world-renowned Licensed Clinical Psychologist experience with compulsive gambling behaviors. He is in Las Vegas, NV, and runs the TOP program.
I.D	4 Response
	Stress relief or escape from problems
	Money in savings account has dwindles
	YES, There are no GA meetings so I rely on the Internet
	The shame, the honest required, the perfectionist in me prevents me from admitting I have a problem
	I need a GA meeting and a sponsor!!! I have 3 years of sobriety with AA and ma very involved and confidant in my ability to remain sober. Wish that same could be said of gambling.
I.D	5 Response
	Gambling... Destroyed my sanity.
	I have destroyed my credit and I live in fear for what they will do to me. My 26-year marriage is close to being destroyed. I live every day in fear, self-disgust, guilt, and remorse.
	NO, A Christian counselor made things worse by trying to impose his beliefs on me (preaching to me). I left feeling guilty and inadequate. "Relapse #???"
	YES, Another compulsive gambler or addict of any kind is my best source for understanding and inspiration
	Some questions were confusing or did not apply to my situation. I tried to answer the best I was able. I have found out that help for someone that has never been addicted to anything although sincere is not much help. GA and CGHub have helped me more than everything else I have tried!!!
I.D	6 Response
	It took away all the happiness in my life...to the point that even when I was winning I wasn't happy.
	It made my boss lose respect for me...got a demotion...my spouse no longer trusts me. I lied, cheated and stole.
	YES, please...the support and fellowship I receive there keeps me going
	Transportation to get there
	Time
	I just never though I would be a CG

I.D	7	Response
		Escapism, occasional wins meant able to gamble for longer
		Lost friends - unable to afford to go out they gave up asking embarrassing for both of us. Became isolated suited me since gambling only thing which excited me. Unable to commit to projects since unable to make arrangements in advance. If I had money gambling came first also concentration poor. Sole possessions for little amounts. Family needs i.e. care secondary to gambling. Missed days at work and would turn up late. Lie without a conscience. Now feeling very ashamed
		NO, didn't help me understand why I gambled or give practical advice. Didn't have any impact on me despite being desperate. Left the office and went gambling.
		YES, group tells similar story of negative impact gambling has had. Recommends 12 steps as a focus to distract from gambling. Going to regular meeting gives me practice at making and keeping appointments i.e. gives me some responsibility. Suspect all male group have different issues and types of gamblers i.e. more action gamblers so about half of meeting I can't identify with.
		Not finding anything as good
I.D	8	Response
		I very often escape from problems
		Loss of money have been gossiped about made me feel like a bad person
		Isolation small town with no meetings, closest three hour drive to and from at night.
		Isolation
		Living in an isolated area is the main problem I would be happy with group treatment program.
I.D	9	Response
		I have not gambled in over 6 years. But when I was gambling, it created an escape for me from my daily life. I thought it was just fun then.
		I had a warrant out for my arrest writing bad checks, I had become a liar, a cheat and a thief to gamble.
		NO, by coming to Gambler's Anonymous I received all the help I needed
		The 12 Steps of Gamblers Anonymous has helped me to work through my life's problems as well as my gambling problem.
I.D	10	Response

	<p>Currently I have abstained from gambling for approximately 90 days since joining GA. But when I gambled, it gave me a chance to not think about other problems in my life. Because of social anxiety, I could sit comfortably in front of a slot machine and not be intimidated. Each time I went, I went with the feeling that I was sure I would win. After repeated losses, I would think my time had to be due, Usually hoped for a win to pay debts, but instead would go further in debt. Faced a depressing long 2 hour drive home and then would realize what I had done, and would spend all 2 hours trying to figure out how to fix it.</p>
	<p>My husband and I have just agreed to separate and divorce. He has not been supportive of my recovery and has not forgiven me for what I have done. It has created a very negative atmosphere at my house, and I feel to recover and to change character defects, it can't be done in this atmosphere. Financially I have not been able to move out yet, but my husband and I are not sleeping together and basically tolerate each other. My 13-year old son is aware we are getting a divorce, and seems to be taking it well. Because of current tension in our house, I have explained that he will get quality time with each of us, rather than living in this uncomfortable situation. We have been in bankruptcy for the past 56 months. Our credit has been destroyed. I withdrew from my family and friends.</p>
	<p>NO, I tried seeing a therapist and did go seven weeks without gambling, but then returned to gambling and sometimes admitted it to my therapist, and sometimes lied about it. In the end, it did not help me.</p>
	<p>YES, Gambler's Anonymous is the reason I am not gambling today. It's been a short 90 days, but I feel the urge has left me (for now). I know this will be a lifetime battle, but continue to be a lifetime member of the GA organization. I look forward to helping others as others are helping me.</p>
	<p>I wish when I called the 1-800 number they would have put me in touch with a GA program, but instead recommended a therapist who was trained in gambling addictions. That therapy did not work for me. When I realized that the therapy wasn't working, I decided I needed more, I checked out a GA meeting (dragged my mother and sister with me) and found out that they weren't intimidating as I thought they would be, and that I was making new friends and people were interested in helping me recover. It has been the best thing I've ever done for myself.</p>
	<p>I'm getting help now, but before, even though I had a problem, I didn't feel like I wanted to stop. I loved going to the casino, and it was my favorite activity besides watching my son's sporting events. When I went by myself, I enjoyed getting away from home, husband, family, housework, etc. I didn't feel I wanted to give that up, until I hit rock bottom and knew I had to give it up or I was going to end up in further financial destruction</p>
I.D	11 Response
	<p>I have survived many hardships though my life, i.e. bad childhood and family life, a very abusive marriage (verbal, sexual and physical), drugs, alcohol, being raped at gun point, raising three children on my own, but gambling took away what ever will power I thought I had and left me with no desire to live like that anymore. Gambling took almost everything from me including my life.</p>

I was fortunate to get into a 28-day program for addictions. It was there that I was introduced to a 12-step program. It was with the help of my councilor and this program that I started to face real issues in my life that I had been escaping from and avoiding all my life. Both the program and councilor allowed to honestly look at myself without feeling like a failure.

YES, Gambler's Anonymous helps to keep me on track in my recovery. It is that constant personal awareness that helps me stay away from gambling in any form. I often use CGHub to make contact with a huge number of friends that have given me support over the years. My family knows and accepts how important my meetings and my GA contacts are for me. It's wonderful to know I am not alone facing this terrible addiction. My family has shown me nothing but support, love and forgiveness...the same as GA members.

Nothing really except for my own unwillingness to except the fact that gambling was/is an addiction and that I could not stop on my own. I suppose that was because I really didn't understand what a gambling addiction really was. Because I always felt like I had failed in so many things and fallen short on my parent's expectation of me, I guess I didn't want them to think that I yet had failed in something else. I wanted to stop gambling on my own...perhaps to show them that I could succeed at that. How stupid that sounds now when I say that. I have nothing to prove to anyone. It's funny but once I accepted my own problems and stopped worrying about what others thought of me, my life started to change...I started to change. You might say I started to grow up.

I.D 12 Response

I have been gambling for the last 10 years of my life. I was the person in our marriage that handled the finances so I knew what we "had or didn't have" as far as extra funds. At first this is what I used. Then when I wanted more I got a couple of credit cards. When they were at their limit I got a few more. Then I signed a couple of checks I received in the mail for "instant loans" at 30%. Before I really realized it I was over \$45,000 in debt without my husband's knowledge. I tried a debt consolidation company but my debt just kept increasing. When I entered a recovery program I did not tell my husband the extent of my debt until 4 months later. The only recourse I had was to file bankruptcy. I decided on a chapter 13 to repay all the debt back. I am now required to pay over \$900 a month for the next 5 years. I make about \$18,000 a year. I know someday I will be thankful that I chose to do this but I still feel so much guilt at all the money I wasted trying to escape into my own little world

of gambling where I was truly in charge. I denied my children many time things and from me so I could have enough money to keep gambling. I lied to my husband all the time then promised when I got caught to because "I loved my family". Even knowing that he was about to leave me didn't stop me. The GA program has saved and is continuing to save my life each day.

Financial disaster...debt...debt...debt. And I was not the person I used to be before I got into the compulsion...the lying, cheating...the trying to keep everything secret.

	YES, I cannot do this on my own and that means I cannot do it with just me and my family and friends. I know in my heart that feeling “accountable” is the one thing that sustains me.
	NO, The last binge put him over the edge. He is not supporting my recovery and has not forgiven me.
	Fear of the unknown and fear of what I would learn and feel about myself
	Until I learn to deal with all the issues in my personal life that created reasons for me to gamble I am/have struggled a lot.
	I just wish there were closer all-women meetings in my area. Sometimes there are things you can share in mixed company but there are lots of times where I feel I could only share things with another woman. And unfortunately there are so few women in meetings I attend so my chances of finding a sponsor are slim. Without a sponsor I am worried about my future recovery in continuing to grow.
I.D	13 Response
	Gambling provided a rush of excitement, a means of escape from negative feelings and fooled me into thinking that a big win would solve all my problems.
	Loss of job, put relationship with husband, children and extended family at risk. Created debt that we couldn’t afford. Led to loss of values, feelings of depression and anxiety.
	Having a therapist/counselor has helped me understand what the first line of GA’s Step One says “we have an emotional illness, progressive in nature” It was very important for me to learn about how my personal history played a part in my mind to escape and my inability to deal with life on life’s terms. Learning to identify and deal with feelings has been crucial to my recovery.
	GA has given me a program of recovery in which I can feel part of a community of other recovering compulsive gamblers. Knowing that I’m not alone and that there are others with the same problem has saved my life.
I.D	14 Response
	It was always a fun pass time for both my husband and me. It was our main form of entertainment. I gambled mostly out of boredom or to escape the mundane of life.
	When gambling stopped being "fun" and more a compulsive behavior for me I stopped being able to trust myself. If I gambled I did so compulsively. I was losing myself emotionally more than financially. I was caught up in mind games continually about trying to find ways to "control or moderate" my gambling. I wanted to "adjust" it and do it on my terms and not being able to cause me so much emotional harm. I was constantly complaining to my husband about it as well. Even though we always went gambling together he always "moderated". Would gamble for a while and then do something else, while I would spend about 20 of every 24 hours on a machine. My life just stopped being manageable because I always wanted to be at a casino, but hated myself when I would go.

	My recovery program has been 95% online with the CGHub and the connections I have made to help me help myself. The 12 Step recovery program of GA has literally changed my life. It is becoming a way of life for me, one day at a time.
	My husband is the type that believes if you have a problem in your life you simply fix it, or stop doing what you're doing that is causing you the problem. We have had much trouble working through my "quitting" gambling. He does not think I need GA and has been very unsupportive of my online activities, but he too has to accept what he cannot change. We determined that we do want to stay married and have been working to find the balance we need. My part is not to "overdue" as is my nature with my online needs for recovery. I try not to indulge my "wants" and do what I feel I need to work a recovery program that works for me. We are both finding our way and our marriage is growing stronger because of the 12 Steps that I am trying to work in all aspects of my life, not just the gambling. It's a new way of thinking and living as I keep working to change what I can in me. I've stopped trying to change my husband's thinking.
	My hope is that Gamblers Anonymous will "sanction" online help sites such as the CGHub for the problem gambler. Recovery is possible online. The number one thing compulsive gamblers desiring to quit have to do is get connected to other compulsive gamblers. That can take any form it does. Online meetings may not be AS effective as f2f but if that is all that is available to an individual, for whatever reason, we can make it enough. The only comment I have about this questionnaire is that the wording for some of the "Yes" or "No" answers was a little confusing. I'm still not sure if I answered the way I intended to. An example is Question 48 . . ."I did not want to get this kind of help." That answer for me was "yes" because I did NOT want to get that kind of help. Hopefully that is correct. Thank you for the opportunity to participate.
I.D	15 Response
	Gambling initially was a fun and social activity, as it progressed I would go and gamble alone, further isolating myself. I felt that gambling numbed me out so I would not think about my problems. It allowed me to escape the reality of low-self esteem and bent on self-destruction, not realizing it only perpetuated the low self-esteem and self-destructive urges.
	Neglect of my children, myself, my spouse, my home, my job, etc. I seemed to have blinders on and was oblivious to just how neglectful I had become. Financial debts, and juggling of finances to cover debts, as well as loans, and borrowing, cashing in of bonds and 401K savings. I had felt so isolated and alone
	I have learned about my family of origin and being genetically predisposed to addictive behaviors
	Connecting with out compulsive gamblers has helped me identify with others and to accept that I am not so unique and alone in my battle with compulsive gambling

		I do think that when I was ready, the help was there. I have had slips, and a treatment program probably would have helped me get abstinent quicker, but my HMO does not cover it to my knowledge. However, I do have a wonderful therapist who has special training in gambling addictions and I feel fortunate to get the help I need there, in GA meetings, and at the CGHub. Best wishes on your doctorate, and please do inform me of the results of your survey.
I.D	16	Response
		It gave me time to myself...time free from the demands of being a mom, nurse, wife, chauffeur, cook, cleaner, shoulder to cry on, friend etc.- while playing the machines, I didn't have to think about ANYONE at all or what they needed from me..... It also gave me peace from my worries - while playing the machines, I didn't stress over the unpaid bills or the upcoming ones and I sure didn't worry about what kind of parent I was for wanting to escape from my husband and children's demands...while playing the machines, NO-ONE asked anything of me as they did in my work as a nurse and at home - I was most often left alone even in the midst of a crowded casino or club..... Finally, while playing the machines, I had inner silence - no more beating up on myself for having over spent all those other days....
		Self-hatred.... lowered self esteem...lack of trust in myself and my ability to control my actions..... Doubts about my sanity...loss of direction and purpose.... major sleep deprivation and all that ensues from that.... mental, physical and emotional breakdown...an inability to accept help / support from family or friends.... marriage breakdown.... major guilt over how my children have been affected..... Mood swings.....
		Therapist] YES, [I continue to see a psychotherapist monthly and explore my childhood / marriage issues, my past conditioning and how that contributed to my gambling... Social worker / Counselor] NO, the social worker - an ex gambler - and I became embroiled in a transference / counter transference issue.... and eventually a therapeutic boundary violation..... A major empathic failure on his part as well as an inability to set and maintain the boundaries of the therapeutic relationship - I consider him and his unethical / unhealthy practices to be the reason my husband and I divorced.
		[Internet / CG Hub] YES, love, acceptance, empathic understanding, support, advice that worked, someone available 24/7, acknowledgement of my experience and sharing from the heart
		My negative counseling experience with the social worker..... A huge amount of fear that my then husband would use my gambling past to take the children from me and that I would not be able to prove that I had quit

In doing my own research into the causes and effects of poker machine gambling, I found mountains and mountains of studies and thesis (spelling?) about gambling in university libraries - almost none of it was available to the general public and what little information I found in public libraries was positively ancient and related to males who gamble excessively. I also found that the research did not address or explain the quitting process and no books / writings (until recently) addressed the issue of what I call the "to-do's" of quitting - I am also really curious as to why no one has yet looked at the frequently reported hypnotic effect of prolonged poker machine gambling and how that plays a part in the 'addictive' process...I suspect that the hypnotic effect induced by intense concentration on the machines, leaves the gambler open to suggestion for some time after each session and that much of the negative self talk that follows losing sessions in particular (e.g. I am such a fool....why cant I stop.....I am so weak / stupid...) becomes a kind of post-hypnotic suggestion that ends up becoming the persons' predominant reality and belief about themselves - the end result I believe is that even a person with a healthy self esteem and sense of self worth can be adversely affected in this way, experiencing a rapid nose dive from essentially healthy to grossly unhealthy.....I see low self esteem (and indeed much of the psycho pathology thought to precede excessive gambling) as a consequence of prolonged exposure to the psycho structural design of poker machine programming - not a precursor to excessive gambling. You might be interested in reading, a thesis written by Sandra Dekker for her Social Work Honors entitled, Commercial Gaming - The Unfair Deal at <http://www.wn.com.au/prohealth/gaming.htm> or a paper by Natasha Dow Schull, entitled, "Escape Mechanism: Women, Care taking, and Compulsive Machine Gambling" which can be read at <http://workingfamilies.berkeley.edu/papers/41.pdf>

I.D	17	Response
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		It created an outing, a way to escape my humdrum life, I haven't gambled in almost 8 months
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		To jeopardize my marriage, my self respect
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		YES, When I didn't know where to turn, the counselor suggested the banning, which I did, and he met with me over a month or so, and helped me tremendously. I found the Hub by divine intervention and it remains my lifeline
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		YES, I was familiar with the 12 step program and it was a god-send to me at the Hub
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		I was blessed in that because of my bi-polar illness and all that has happened to me in the past 20 years, I knew I HAD to do something...it wasn't normal to run to a cash machine in a daze; I was frightened into getting help really. I also had done the 12 steps at church and had come to understand ME and my terrible childhood, so banning myself from the casino was a very empowering thing, and of course the fellowship at the Hub
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I.D	18	Response
		Gambling took over my life. Made me disregard the well being of my family and the relationship I had with them. Gambling made me care less about myself and the outcome of my actions. Gambling is like an addictive drug, if not worse, because there is no physical withdrawal.
		Loss of job due to theft. Subsequent court action caused much pain and anguish to family. Had to sell and move to try and cover this theft. Loss of employment benefits that would have been available upon retirement. Actions a matter of public record, therefore causing difficulty in obtaining other employment.
		YES, My counsellor helped me get through dealings with police and the courts
		YES, G.A. is my redemption. Meetings, steps and therapies have helped me on a path to a new life. I am finally starting to see there is something to be gained by accepting who I am and dealing with my life on a day-to-day basis.
		Denial
		Most problem gamblers don't seek help because they are not ready to accept their life is unmanageable. The first step to recovery comes when we admit we are powerless over our addiction. No amount of assistance will be of use before we are ready to admit this to ourselves.
I.D	19	Response
		Gambling controlled me. I bounced checks regularly, borrowed often, went bankrupt, almost lost everything including husband and daughter and had fear of going to jail.
		My husband could not trust my judgements on paying bills, always questioning me, creditors were always calling, went bankrupt. Husband was threatening to leave and take our child, disconnection notices on all utilities, and bounced checks all over the place.
		GA 7 years
		Not really sure I had a gambling problem; it was just scratch off lottery tickets.
I.D	20	Response
		Gambling made me a careless selfish person who only had one thing on my mind
		Gambling was my life. My husband and kids were always second to my gambling
		NO, At the time I went they were trying to treat me as an alcoholic and it didn't work at all

I.D	21	Response
		It made me a space cadet. I would avoid life and its problems. At one time it was a relief because it stopped the day-mares I had. It broke the contest visions of terror. But in the end it was as bad.
		Financial, health, relationships. I would go with very little sleep for days and weeks at a time. I didn't go to doctors or dentists when needed unless I collapsed as I did.
		No, I was placed in treatment for depression due to suicidal depression but gambling wasn't brought out as an issue to me.
		YES, I have almost 2 ½ years clean and I know it is only because my involvement in GA
		I stay away from treatment that has women involved because I have had bad experiences with women both counsellors and other women. I have had good experiences with men though.
I.D	22	Response
		I liked being in the casino. It caused me to lose my son. I stole money from his company
		I lost my son, my job. My son and \$100,000 in 8 months. I am trying to get my life back together.
		I have been going to GA and it has helped a great deal.
I.D	23	Response
		I was responsible for losing all my assets. I lost my house, car, most of my personal possessions. I was twice admitted to a psychiatric ward for depression as a direct result of my gambling. I went to prison for three years as a result of a staged armed robbery where I had a plastic gun and wanted the cops to shoot me. I made several other suicide attempts. I gambled because I could zone out of the real world and it provided me with a great escape from myself.
		NO, I have relapsed several times
		NO, My family and friends have a very limited knowledge of compulsive gambling and cannot relate to it. I live in a small town and GA is not available.
		In the early years of my gambling it was virtually impossible to get formal help. Only in the past few years has help been readily available but I have to fight to get into a treatment centre.
I.D	24	Response
		It has upset my family and now both my daughters are following the pattern.
		A counsellor has helped to see my weak points and why I would go out and buy tickets
		My husband has tried but doesn't understand the way that my friends at GA have made me feel
		I don't want family to know about my gambling problem

The amount of happiness that it gave me or a high		
I.D	25	Response
Gambling has ruined my life! I've attempted suicide, lost respect of family and friends. It has overall been the worst thing I've ever done. (see Dear Gambling letter)		
YES, Has controlled it some what but I still turn to gambling when things get my mind down		
NO, Most do not understand the addiction and don't support my efforts to stop		
The loneliness (I'm a widow) is my biggest setback.		
<p>Dear Gambling, Well you did it! You took all that I had to give and then some - money, respect, pride, tears, sleep, love from family and friends - I could go on but you get the idea. Today I signed personal bankruptcy papers; next week I'll lose my car. There's nothing left to take - except my life and I'll be damned if you get that!!! I used to have fun with you. In 1978 Harry and I went to Las Vegas for a vacation. Our budget for gambling was \$20 daily. I'd get \$5 in nickels and he'd get \$15 in quarters. We left Vegas with more than we came with. And we had FUN. In 1986 I went back to Vegas with my mother. I played a lot - but only because I could smoke in the casino. I also won a lot. Still no big deal - I was still having fun. You didn't have me yet!! Between 1986 and 1998 I was in a casino perhaps 4 times. I could go in with \$100> and win or lose, it didn't matter - I had a good time. You hadn't hooked me yet and I didn't think that you ever would. Then, one evening in lat June 1998, the doctor told me Harry had liver and lung cancer and he had just 3 to 6 months to live. After 30 years of coping (and not too well) with his drinking, he would die of cancer. He had joked about it but I always thought that's what it was - a joke. An alcoholic dying of cancer - I don't think so! It was Thursday night, my payday - I left the hospital at 8:30 and through the tears I drove 2 ½ hours to Rama. I stayed all night - I must have won or wouldn't have lasted that long. I wanted to be in a place with people and noise and be all alone in my misery. NOW, you had me hooked - I had found the place to escape to forget about all my problems and be isolated in a large room full of people. Harry didn't last even 3 months; he died 10 days after that Thursday night. He was in a lot of pain, and told me it hurt to breathe. This big strong man that I'd been with for 37 years - who never said anything hurt - was HURTING. In his next to last breath he told me he loved me. The everlasting picture in my mind was a skeleton in a hospital gown. After that, the 7's on the slot screen took away that image - or any other slot machine screen. The picture never goes away for long. At first I didn't see much - maybe once a month, then every few weeks. But you were slowly edging your way into my life. The first year wasn't bad - you were a diversion from the day-to-day routine that I now had. I was busy re-decorating the house and kids were around almost every weekend or sometimes more often that. Then, when the house was sold - you were right there - because now I had MONEY. After moving, I was alone more and more. But now when I went to visit my wallet. I was lonely</p>		

and terrified of being alone. And I had money. But not for long, you saw to that. After a year of almost steady gambling, I was broke and had to sell another house. OH, OH!! You got me again. The biggest triggers were there again - MONEY and LONELINESS. It didn't take long this time before I was broke again. Then the bad stuff started - the lies, the excuses, and the cover-ups. Nothing seemed to matter anymore - just going to visit my best friend the slot machine. You didn't care that I was now ugly and fat. You didn't care that I was crying out for help in my head. And you really didn't care that you were killing me bit by bit each time I saw you. You gave me solace when I needed it the most. All I had to do was keep buying your love and you welcomed me with open arms. Finally, it is over!! Our love affair has ended. It's been a long romance with a lot of bumps and potholes along the road to recovery. But I can be very stubborn and strong when I have to be and now I have to be. My groups have given me the courage to be me and to cope with life as I'm handed it - good or bad. I'm going to work my new recovery program. I'll stick to it with a vengeance if I put half as much effort into it as I did you, I CAN WIN. Somewhere between my program, my group sessions and counselling I can end it and not look back. Maybe, just maybe, I can earn back some of the love and respect from those that I care about. If I don't then to Hell with them AND TO HELL WITH YOU. Good-bye and Good Riddance

I.D 26 Response

Coping behaviour to escape loneliness and stress of marriage. Could go alone at any time of day. Could talk with other gamblers or not. Felt welcome, knew a lot of staff at establishment. Got to recognize new gamblers.

Financial distress, son's behaviour is more negative. Strained relationships. Poor credit. Negative self-esteem and self-respect.

Currently at 60 day program at Bellwood program at Bellwood. Attended Amethyst Women's House for additional support. Psychiatric support for depression.

Attending GA and AA regularly to work thru steps and gain understanding that I am alone.

I.D 27 Response

When I entered a casino I felt a rush of excitement as if I was on a holiday. While gambling I was not bored, did not worry and at first felt at peace. After when I started losing I became angry at the casinos, the slots, myself for being and idiot for playing. I left feeling depressed, determined never to go back. I felt seedy, a loser and out of control. I felt guilty for lying to my spouse about where I was.

My husband of 31 yrs. Threatened to leave me if I didn't stop wasting the money he worked hard for. All the emotional problems I described in Q.43.

NO, I just sought help from GA

I received help from GA

		This is how I felt about getting help from GA initially but I overcame these problems and sought and am still getting help from GA.
		I think GA is an excellent tool for preventing me from gambling. It is important to attend the meetings regularly and never forget the misery gambling has caused you and your family.
I.D	28	Response
		NOTHING
		Financial disaster
		In a very short period of time I feel no urge and have given my spirit to a higher power. Sharing is wonderful - being with people that understand the addiction is helpful to me.
		NOTHING - I just loved the action. Lights - noise - people (24-7)
I.D	29	Response
		Gambling was my escape from the problems in my family and marriage. I only realized this since I've been in therapy.
		I lost my job, for stealing. I almost lost my husband. The financial problems are still there but getting better.
		YES, It helped me realize why I turned to gambling.
		YES, They made me realize I needed help and asked for it
		Seeing that I'm receiving help a lot of these questions did not apply to me. Once I admitted I had a gambling problem, getting help was my only salvation.
I.D	30	Response
		Make me escape from worry and troubles
		Every aspect in my life
		YES, From my first meeting 12 years I day, I have not gambled. I have a better way of life today. My life has turned completely around today. I'm involved in GA. Started 2 meetings that are going great as of today.
		One day at a time. Gamblers Anonymous meetings work. Program works if you want it to work.
I.D	31	Response
		Gambling caused me to lose a great deal of money over the years. I thank God I have an understanding husband or I might not have a marriage.
		Late Paying bills. Having to borrow money and lying to my spouse.
		YES, I see a GA counsellor every 2 weeks. I have an agreement to attend ten meetings pay a co-pay and the state pays the rest
		YES, I have pressure put on me to buy raffle tickets from my UAW local, my church or bingo at my arts and crafts. My husband, family and friends don't try to influence me.

		I knew I was hooked and wanted to stop yet had no will power to control my gambling. Until finally I was pushed against a wall and there was no way out except straight forward. Now I'm successful in not gambling.
		I just thought it was alright to gamble and I had everything under control
I.D	32	Response
		I am not gambling NOW, as of 11-03-02. My last date in casino was 7-03-01. By coming to meeting (GA) has helped me to stay away. They help me to see that pick "\$" hell is still there for me if I choose to return.
		YES, Family, friends, GA meeting, taken on leadership role by helping out to form our groups.
		My experience with Intergroup - Racial over tone took place. Our group was taken off the GA listing without consideration of how many people were in need of GA support. There was discrimination of people voting to remove our group from the listing. It has now been added but racial overtone is alive and well in our city of Detroit.
I.D	33	Response
		NO ANSWERS
I.D	34	Response
		Financial, health and relationships
I.D	35	Response
		RECREATION and escape from difficult problems
I.D	36	Response
		Making me depressed. Sleeplessness. Owing money
		Trying to stop but thinks will have to win to get back lost money
		Put me in debt
		YES, Counsellor helped me about 4 yrs ago.
		YES, GA helped for awhile
		NO, Friend is a gambler
		Good questionnaire. I and only I can decide I have a gambling problem and seek help
I.D	37	Response
		I have been attending GA since June 2001. In my addiction reality was warped. The highs were high and the lows were devastating. Life is normal now.
I.D	38	Response
		I am over socialized. It got me out where the action is without having to talk to people. I was spending far too much money and found it to be expensive fun. I had difficulty quitting on my own so I joined GA.

	Indebtedness
	YES, therapist and group therapy gave me an understanding of addictive style of gambling
	NO, Therapy taught me that I should only need to stop my game of choice. GA tells me that I need to stop all forms of gambling. Thus, a serious conflict!
	YES, supported from group (2) a way of life that arrests the compulsion to gamble
	I love to gamble. I just cannot afford the losses I was incurring
	Just as most sober alcoholics end up in GA, I think most non-practising gamblers will want to end up in GA. I think educators (therapists) should concur with GA or visa versa so there will be no conflict for the person seeking help in stopping gambling.
I.D	39 Response
	Real high that I enjoy which I'm doing it, but I lose all the time
	Just get the money back! Lost over \$500,000. Just want one more women
	Stress in my family. Don't cook and eat out every night. Don't do housework; don't see my friends and family and grandchildren. After losing I just want to sleep and not wake up. Find a way to go to the casino.
	NO, have never gone to them and family doctor does not know how to help with gambling problem.
	YES, listening to stories I know I need to stop before I lose everything. People talking in therapy. I still can save myself, not lose my house, not split up.
	I didn't know you could get help and went to the family doctor
	If I have to stay like this torture, shaking, not sleeping, and eating junk food. I wouldn't want to live causing pain with fibromyalgia and I can't handle the pain. Stressed out from gambling.
I.D	40 Response
	Gambling ruined my life. I lost a management position of 22 years, lost all respect of colleagues and friends. I lost myself; my own self-respect and it led me to commit criminal acts, which I would never have done.
	Financial - nearly lost family home did lose all family savings, respect of children, my husband and myself. Health - aggravated arthritis, migraines etc. Lost most friends.
	YES, I saw a forensic psychiatrist to help with my legal problems and he was able to open me up so that I was receptive and ready to work on my emotional problems with an addiction therapist. My therapist was also a compulsive gambler in recovery, which I believe helped her to identify my issues, and made it possible for me to trust and relate to her.
	YES, Without the support of GA members and meetings I believe I would be dead now. They supported me and shared their strength with me. They talked with me as much as I needed and gave me hope when I had none.

	All kinds of help are needed for compulsive gamblers, but I don't believe any of them would work without gamblers anonymous. It is the pivotal ingredient to recovery.
I.D	41 Response
	Gambling "almost" ruined my life
	Family discord, financial ruin, loss of self-respect
	NO, sounded good filled time, but really didn't help
	YES, everything there rings true - we all really connect
	Not knowing where to turn, thinking gambling was my only resource to obtain additional funds
I.D	42 Response
	Gambling caused me to think less of myself and help others to gamble. It has caused me to go in treatment and learn much more about myself
	To over extend my budget through checks and credit cards. To lower my self-esteem and trust myself
	YES, IT is helping me to understand myself and my addiction. It allows time to think, prayer, listen, discuss and receive help in a safe environment
	YES, GA meetings have been helpful, giving support and companionship. My family and friend have supported by words and prayers.
	Pride, stubbornness
	As a religious woman, the fear of the example set by gambling was great
I.D	43 Response
	No Response
	Gambling has caused me to be excited, guilty, worried, and disappointed at the same time. Most days I would wake up (if I had slept) and the first thing on my mind was how much I was in the hole and that I needed to get to the store and buy some 'scratchers' to break even It also has nearly ruined my relationship with my s/o and has almost caused me to lose my happy home...staying away from gambling has given me new hope and new emotions. It is so much nicer to think of my family instead of gambling.
	YES, it has given me the chance to tell someone how I feel without being reminded of all the mistakes I have made and all the debts I have made.
	YES, it has given me the chance to tell someone how I feel without being reminded of all the mistakes I have made and all the debts I have made.
	He doesn't understand why I can't just walk away and not gamble...he thinks I am just selfish and inconsiderate and irresponsible.
I.D	44 Response
	I am living the 12 steps

	Loss of time rather than money
	YES, I received help in N.J. and am grateful for all I received even though I didn't accept at times there
	YES, I go to 4-12 Step Meetings a week. G.A. meetings are profitable. It's a "we" program!
I.D	45 Response
	It gave me an escape; it gave me a high at the beginning. I've been in GA for 4 years. I have relapsed 4 times the last time after 22 months of being clean, now it's been 42 days that did not gamble. Gambling is no fun since I've been in G.A. I do not have the same feeling since it really destroyed me inside, felt ashamed and no good, but today I feel good.
	Gave me debts, headaches, heartaches, had no life. No concentration in my life all I had was misery and self-pity. I had a bad life at home with boyfriend and daughter, and was not really at work even when I was there.
	YES, the ONLY help is GA.
	I never had a problem getting help from GA
I.D	46 Response
	Good escape somewhere to go to be alone
	Spending too much money
	I enjoy it. It's my timeout away from everyone. Because I hate T.V. and there's nothing else to do. I hate Hollywood so I don't go to movies.
	You need one GA closer to where I live. I have to drive 45 minutes to a bad neighbourhood to attend.
I.D	47 Response
	Helps relieve the loneliness from living alone. Keeping me broke (financially) morally. Gave me something to do that I didn't have to depend on someone else. Slowly was taking me more and more into isolation and self-destruction
	Money not enough to pay bills - have gone bankrupt. Not at work for 1.5 years. Loss of friends and family members. Don't keep home tidy when gambling. No quality of life. Brought me to the point where I was suicidal, hopeless helpless, worthless.
	YES, CAD services in Guelph (weekly therapy meeting with a counsellor present, plus one on one visits to her.
	YES, GA member sharing makes me feel that I am not unique in my illness.
	Doctor told me I should just "quit". Doctor not understanding the severity and complexity of the illness. Lack of "INFO FOR PUBLIC CONSUMPTION" readily available. The unacceptability of this addiction as a sickness because it is not something (a substance) that is ingested.
I.D	48 Response
	Shopping gets control back from my husband.

	Don't want my husband to have all the power. He abuses it.
	Made me be dishonest and break values
	YES, my counsellor/psychiatrist tries to get me to look at it sometime I do.
	Husband
I.D	49 Response
	Destroyed my self esteem on all levels while gambled physical, spiritual, emotional, financial
	Financial - drain on household. Emotional - feeling raw. Spiritual - Forgot God. Hurt others and self by withdrawing
	YES, GA Meetings ad support of spouse. Commitment now to GOD. Spouse supports meetings. I've started in community.
I.D	50 Response
	It was my escape from life, a way to spend time not thinking about life
	Financial calamity, marital problems
	NO, psychiatrist treated symptoms, and not the problem. Diagnosed with depression, take pill, that will solve the problem
	YES, started with alcoholics anonymous and then gamblers anonymous. Found understanding and understood the problem was me.
	No formal treatment plan worked for me. It took a 12-step program to show me the way.
I.D	51 Response
	Gambling made me happy when I went I didn't worry about anything, I felt great, but the emotions were sometimes terrible, when I lost I was in an awful state of mind. I wanted to kill myself because of the burden I put on my husband with the outstanding loans.
	It almost ruined my marriage but luckily I have a special husband who encouraged me to get help. I wanted to commit suicide.
	None just was to afraid to admit it and ask for help
	I wish their was a GA program closer to where I live and that they had an all women one I have yet to find one I have noticed over the last few months of going that women do gamble for different reasons then men and it would be helpful to sit and talk to women about that instead of the regular GA meetings where people are talking about everything under the sun.
I.D	52 Response
	Helps me to forget my feelings. Escape.
	Financial problems. Depression.

	YES, Started counselling. Good therapy one on one.
	YES, Great help. Twelve steps are fantastic
I.D 53	Response
	It has lowered my self-esteem to the point I felt I was worthless. I have gone bankrupt and I am still in bankruptcy
	I have gone bankrupt. I have lost all my equity and all my RRSP's. I must start over at 54 years old.
	YES, ADAPT counsellor has helped me get grip on my addiction. She has helped me gain self-esteem.
	YES, I am not alone. I am not bad
	Not many people close enough to me to notice I had a problem.
	Denial
	Not enough promotion about where to get help and the no cost of ADAPT and GA. There are lots of people who need help and not getting it.
I.D 54	Response
	Gave me an escape from reality
	In the past it affected my relationships, work and everyday life.
	YES, Therapy has helped with dealing with emotions and repairing the damage in my life
	YES, GA is #1 in my life without it I don't have a life.
I.D 55	Response
	Started with slots then blackjack then Caribbean stud poker then baccarat.
	No real relationship with child and husband. Not really good at work. Loss of sleep. Not eating well.
	YES, all of the above have helped immensely. I have stopped blaming the people around me.
	YES, These people have understood by the grace of God.
	I think that it is great someone has even considered female gamblers
I.D 56	Response
	Gambling resulted in loss of job, possible criminal charge, loss of all I value and loss of interest in life.
	Loss of production at work and loss of time. Negative reaction from boss, fight with my mother, problems eating, sleeping, loss of memory, ambition, sexual interest, stress. Dreaming of ways to commit suicide, problems with the bank, loss of financial security, seeing that I was to become a bag lady.
	YES, Bellwood helped me get a start, a big start in recovery

	YES, GA is a tremendous help. I need this regularly.
	I did not want to stop what gave me shelter from everything I feared and hated about my life.
I.D 57	Response
	Made me ignore ethics, morals. Made me obsessed with its pursuit and forget all else. Destroyed my life: health (physically), sanity (mentally), promiscuity (emotionally), spiritually. Ruined long-time relationship
	Financial bankruptcy, relationship break-up, decreased marks in school, family doesn't trust me.
	NO, I tried many councillors and psychiatrists but they couldn't understand the "rush", I would get more down after and continue.
	YES, GA has helped me tremendously. Everything I have wanted I received after learning about myself via GA.
I.D 58	Response
	Gambling consumed my day. I had to lie, cheat, steal to enable my gambling. I have done things about my children's welfare that I would not do if I didn't have this disease. I have been gambling free for the past 4 months. As a result we have money in the bank, and I am playing a more active role in my children's life. The lies are gone and I am not agitated. Learning to say no, which I couldn't do before my gambling.
	Lost home, had to declare bankruptcy. Husband has difficulty trusting me. Have not attended family functions. Did not participate in children's life.
	YES, Had individual counselling that did help. Only problem was it was only once a week and was only a 12 week period.
	YES, Tried G.A. several times over the past 5 years. Only the past 4 months as a GA member have I really found peace. I attribute that to individuals counselling I have been receiving.
	I love gambling and knew if I got help for it, I couldn't gamble
	One treatment centre I attended tried to teach me to gamble responsibly. This indicated to me the counsellor was not very knowledgeable about gambling. I wonder if an alcoholic would be told it is O.K. to have 2 or 3 drinks but not get drunk, so why would you tell a compulsive gambler just spend \$30 or \$40?
I.D 59	Response
	YES, one on one therapy with an addiction therapist. I was able to fully open up and share my experiences.
	YES, sharing and hearing similar stories to mine really helps and helps you and feel like I'm not alone
I.D 60	Response
	Gambling allowed me to "run" cover up" feelings of loneliness, fears and inadequacies at times it was a way to celebrate "a good day" It helped me to be where I had "no responsibilities"
	A big debt. Lack of trust from family and friends. Feelings of shame and guilt.

	YES, residential which includes group psychotherapy, bioenergetics, physical fitness and spiritual direction and counselling. It was a holistic approach.
	YES, GA and AA - people who can in their honest sharing helped.
	YES, A co-dependent relationship. I could not be honest completely with this person.
	Feelings of shame!
	Awareness of a problem and my own lack of honesty, self-deceit.
I.D	61 Response
	Played Nevada tickets, Bingo. Gambling ruined my marriage, no money, and no trust.
	Separated, no money, no respect
	YES, therapist, counsellor, psychiatrist
	YES, Gamblers Anonymous
	Lying
	Not being with husband
I.D	62 Response
	Entertainment. I haven't gambled in 2 years
	Cashing my stocks, not having that money
	Counsellor at PGA (Windsor) was a great help
	GA on a weekly basis
I.D	63 Response
	Gambling did nothing positive for me. On the negative side, it meant I ate poorly, had no money for clothes or house repairs. It was a poor existence.
	Poor diet. Cheap birthday gifts. Cheap Christmas gifts. Old clothes. Second hand clothes. Home in need of repair.
	YES, Gambling Prevention Services helped most with a counsellor then with their after care service.
	YES, Gambler's Anonymous keeps me bet-free as I have only missed one Monday night meeting in 1 3/4 years.
	I didn't want to stop
	Loneliness
	I had to make up my own mind to look in the phone book for Gamblers Anonymous. I only found Gambling Prevention Services. This was a break for me.

I.D	64	Response
		I was an escape gambler. Used it to relieve stress, escape worry and problems/
		Emotional breakdown, cannot cope with life while gambling. Financial problems, off work on sick leave. Attended a treatment centre. Had 7 months clean then relapsed. Co-dependency issue and poor relationship with gambling partner a strong influence
		YES, All of the above. Still attending After Care Program at Gambling Association (Windsor). Have been going there for 1 year. Did 12-week course, 12 week after care, individual counselling, residential treatment, etc. EAP, Dr. and Psychiatrist.
		YES, GA and friends from program. I also belong to AA.
		Afraid of losing partner, it was our main activity, nothing in common now.
I.D	65	Response
		Gambling took away my ability to think and decide what is best for me. Both physical health and emotional health
		Financial, Emotional. Now I think twice about recreational fun and what I want to do. I think about gambling as a problem for me every day.
		YES, Gambling Treatment Service Counselling helped me see and admit I had a problem that needed solving and I could not do it on my own.
		YES, regular GA meetings (weekly) for the past 4 ½ years have helped me to stay focussed on my desire to stop gambling and that I cannot EVER gamble again.
I.D	66	Response
		When gambling didn't have to think about anything - no need to worry about anything seemed as an escape in that environment.
		Money problems, because it costs money to have this addiction
		NO, I have been attending GA meetings instead of the above (formal treatment). I have found this kind of therapy to be the best for myself
		YES, I find that attending meetings once or twice per week has helped me a great deal. You are with people from all walks of life who share the same problem and understand your struggles with this problem
I.D	67	Response
		Gambling was an escape from facing the loss of my husband to lung cancer - fill the loneliness - then escape from my illness of also perhaps lung cancer. It does not really help in the end. The Problem is still there. All it really does is cause great financial difficulty and remorse and great unhappiness
		Financial difficulty. Unpleasant attitude toward family and friends. Sleepless nights. Health problems from bingo in smoky areas. Basic friends mostly all gamblers and that's all we did together. But your not really together because each person goes off on their own (loneliness again).

	YES, I have a counsellor at Problem Gambling (Windsor). She helps me with discussing my problems > I began a 12 week recovery program - did not complete it. I really don't care for the approach - I do not like all the written homework - I feel it only keeps the idea of gambling constantly on your mind - did NOT find group therapy that rewarding in this particular program.
	YES, Gamblers Anonymous has helped me tremendously even though I gambled only 2 days ago. I went under great health stress - possibly cancer and used it for a few hours of escape. But, I returned to G.A. meeting the next night. I find GA group therapy very rewarding and helpful. Everyone is not judgmental or accusing, questioning - the key word here is understanding and great support. After a meeting is still on going therapy - I have nothing but praise for this program and Hope I make a 1-year pin at sometime. I continue to take ONE DAT at a TIME. <u>I will make it.</u>
	What to do with spare or free time especially weekends when alone. Holidays when others are with family my family away on holidays - again - boredom - loneliness - escape from illness or worry - hoping to recoup finances.
I.D	68 Response
	Helped dull the pain I was going through - great escape.
	Financial, family - trust issues, medical problems, attempted suicide
	YES, Homewood in Guelph - taught me to change my life style and to deal with the problems causing the pain therefore eliminating the need for escape. <u>Balancing the needs in my life and working on character defects.</u>
	YES, more that a support system - it's a very close group of friends who share the same illness as I do. Some friendships are the closest that I've ever shared in my life (we laugh, we cry, we celebrate and we support one another in times of sadness and joy).
	Scared of the personal debt I owed.
	This survey was very well thought out to address women and gambling. There are many questions that were never asked of me as a woman. It is much more acceptable to be a man and gamble than a woman. It's time for a change in attitude in society.
I.D	69 Response
	Made me depressed. Twisted thinking (I was stealing but convinced myself I was borrowing and would pay it back) Kept me from spending time with family and friends. Turned me into a liar, thief, cheat.
	Almost lost my family. Almost got arrested. Embezzled from employer. Still paying back debts. Lost trust from spouse. Hurt family, friends, and co-workers.
	YES, helped me to understand that it is an illness and I had no control of the situation while gambling. I was not alone. Helped me build my self-esteem. Helped keep me from stepping back to gambling.
	YES, made some of the best friends in GA. Gives me a place to vent. Everyone understands. Don't want to disappoint the group.

I.D	70	Response
		Made my life very miserable, escaping from problems. Was very self-centred and selfish.
		I still have problems with my controlling critical mother.
		YES, 3 different psychologists. Still see one when needed.
		<u>GA a must.</u> Plus my husband does Gamanon.
I.D	71	Response
		I totally was a person who could make a person feel bad if they did not give me money. I wrote bad checks, used others credit card, pawn family jewellery.
		I have no urge to gamble now. I am working on my character defects.
		I wanted to die
		I was open to help after my 1 st meeting. I have not relapsed since becoming a GA member.
I.D	72	Response
		made my life so bad I wanted to die
		Lost respect. My husband and daughter did not like me. I did not like my life.
		I could not make it with out GA. The support is great.
I.D	73	Response
		Could get absolutely away from all problems. Felt important - had my own money that didn't have to be accounted for could buy things for grown kids and others was the big shot.
		Lost trust - reputation and self image was probably with all the self imposed pressure developed health and heart problems.
		All of the above, husband has been a member of 12-step program for 32 years and so are all of our friends.
		Seeing how concerned spouse was about me and seeing how hard he has worked and telling him the truth. Losing 6 ½ acres - having to sell it to close the company I had run into the ground. Need some money? Write a check.
		Self said if I try to do this look at what I'll be missing. Won't be able to go to functions with "friends".
I.D	74	Response
		When I gambled I temporarily escaped from the pain of leaving a job (teaching) that I had loved. It let me forgive - for the moment - my troubled home.
		I have lost an enormous amount of money, which I will probably be repaying for the rest of my life. Far worse is that I have lost my children's trust.
		YES, seeing a therapist: 1. Helped me understand the motives that first prompted me to go to the casino and 2. Helped me proceed with my recovery.
		YES, GA and my friend have helped me follow a no-gambling course and have encouraged me to find better outlets for my energy.

I.D	75	Response
		Financial problems, self-esteem, self-respect
		YES, I feel like I belong to something. It gives me somewhere to go and I don't feel so lonely and isolated.
		I enjoyed it!
I.D	76	Response
		YES, being with people that understand me.
I.D	77	Response
		It helped ease the pain of emotional crises and emotional insecurities
		I embezzled money. I was prosecuted. It has hurt me financially and my job and career.
		When I came into GA I didn't think that I needed since I moved from where I gambled. By staying in GA I learned that no matter where I am I need to be on guard regarding my addiction
		Being in my addiction and not wanting to stop because I enjoyed it
		I think that Q. 76 (not knowing what help is available in my area) is the main reason that keeps me from seeking formal help.
I.D	78	Response
		It was an escape from life, sit in front a slot machine and tune out the whole world
		My husband couldn't handle the pressure of my wiping out the checking account and maxing out the credit cards. We separated in December of 2001.
		YES, after suicide attempt in January 2002. I've been seeing a psychiatrist on a regular basis.
		YES, GA meetings several times a week. My sister handles all of my income for me, and helps me work out a budget.
		NO, he thought that I should go away and get cured and then come back home.
		Not wanting to admit there is something I am powerless over.
I.D	79	Response
		Kept me from being lonely so I thought.
		Social problems
		YES, out-patient with my therapist
		YES, went to a GA meeting and stayed

I.D	80	Response
		Gambling robbed me of my self-esteem and will to live. I had been a successful career woman, single mom - totally responsible. Gambling became more important to me than anything else!
		Financial - I'm now in a Debt Management program. Marital and Family - my partner and my children are angry with my behaviour.
		YES, I saw a therapist trained in compulsive gambling. She took a hard- line approach and told me that until I stopped gambling there was nothing that I could say that she could listen to (addictive thinking). It was the best think she could have done. I stopped gambling, went to GA and continued therapy.
		I first went to GA 4 years ago. Although I slipped, I continue going to 2-3 meetings a week.
		Fear of repercussions from going public about my disease/problem
		Guilt, shame and disbelief in the ways I behaved.
I.D	81	Response
		Ruining my life. Ruined my reputation
		NO, my brother needs money for college. His loan is currently under appeal.
		I am behind 1 month rent. I have begun to lie more about my whereabouts - when all the time I have been gambling. I owe lots of money in past bills (I never really learned how to manage bills while growing up)
I.D	82	Response
		It gave me a chance to dream - unrealistically
		Big financial problems
		YES< GA has saved my life. I practice the program one day at a time.
I.D	83	Response
		Gambling allowed me to escape pain and fear
		Financial problems, self-esteem issues
		Yes, my counsellor was an addiction counsellor but was not trained for gambling. He helped me understand the cycle of addiction. This only lasted 3 months. GA became my driving force.
		YES, GA has allowed me to change my life. The 12 steps taught my about responsibility.
		Both of my parents and several of my siblings are active in recovery
I.D	84	Response
		Numbed the pain, escape the reality
		Parkinson's disease diagnosed. Parents in 90's needed attention and care. Son in financial debt - bankrupt. Retired early. Arthritic hip.

	YES, attended 12 sessions with gambling counsellor - went back out but eventually returned to program
	Not wanting to face progressive disease, loss of parents, hip surgery
I.D	85 Response
	Causing misery in my life
	Financial problems, low self-esteem, inferiority complex, marriage problems, no ambition, social isolation
	YES, seeing a counsellor
	YES, Easier to open up and be honest about gambling. Easily accessible and feeling of acceptance.
	I'm getting help now
I.D	86 Response
	Not sleeping, guilty, lying.
	No retirement because I cashed my 401K. Postponed a marriage because of gambling problem
	NO, I was not ready to stop gambling
	YES, I am ready to stop gambling and accepted I can't do it on my own.
	Help is available here in Arizona. I think that I cannot gamble like normal people was the hardest for me to accept.
I.D	87 Response
	Gambling almost destroyed my life. I wanted to die because of gambling
	It has caused me to loose closeness to my family. I am now divorced due to my gambling. I have not been a very good mom due to my gambling. But due to my gambling I have met some of the dearest friends through going to recovery and also am finding a life I never knew I could have.
	YES, I do online GA but I also attend other 12 step meetings for my gambling problem. I have no f2f GA meetings where I live and so I take what I can get
	Making my family more ashamed of me than they already are. Also there are no treatment centres for gambling around where I live.
I.D	88 Response
	Made me a liar, thief and someone I no longer knew
	unhappy home life
	YES, I have to say yes and no, private therapy helps to get to the underlining problems that have caused the gambling addiction, GA helps with the gambling problem
	YES, helps me to understand that I am not alone in this addiction and the fellowship holds us together

I.D	89	Response
		YES, Counselling and group therapy has given me the tools I need to beat this addiction
		YES, the CGHUB has been an invaluable source of support and inspiration
I.D	90	Response
		No Responses

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